Evaluation of the Health Screening and Notification Program

Research and Evaluation Division
Citizenship and Immigration Canada

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Technical Appendices

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1.0 Methodology

1.1. {PRIVATE }Evaluation Approach and Issues{tc \l 1 "1.3 STRUCTURE OF THIS REPORT"}

In keeping with the requirements of the *Directive on the Evaluation Function*[1], the evaluation was designed to examine two broad issues: the relevance and performance of the Health Screening and Notification (HSN) Program.

A program logic model (see Appendix A in the Evaluation Report) was used in the design of the evaluation, which depicts the activities, expected outputs, and expected outcomes for the HSN Program. This logic model was supported by a detailed evaluation matrix which articulated the evaluation questions and indicators. The expected outcomes examined in the evaluation were:

- immigration medical examinations (IMEs) are conducted;
- applicants who have a disease of public health significance or a condition imposing excessive demand are identified;
- individuals who have the potential of posing public health risks are connected to the provincial health system;
- migrants who pose risks to public health or public safety are admitted with condition, are refused entry, or are declared an excessive demand to Canada; and
- the HSN Program reduces the burden of migration on the health and social services in Canada.

The evaluation design was calibrated in accordance with the overall risk of the Program. A large-sized evaluation was conducted with the level of effort based on several factors including: the high relative materiality of the Program; recent changes and new tools introduced to the Program as a result of Citizenship and Immigration Canada's Modernization Initiative; interest within the department to assess various policy issues; and no previous evaluation of the Health Screening component of the Program having been completed. As a result, a comprehensive evaluation using multiple lines of evidence was used. (A list of evaluation questions is presented in Table 2.1 of the Evaluation Report).

1.2. Data Collection Methods

1.2.1. Document Review

A review of both Federal and Provincial government documents, as well as a review of national and international stakeholder documents, relevant to the Program was conducted to provide information for most of the evaluation questions. Key documents reviewed included:

***Corporate / accountability documents*:** including Citizenship and Immigration Canada's (CIC) and Public Health Agency of Canada's (PHAC) Departmental Performance Reports (DPR), Reports on Plans and Priorities (RPP), Departmental Strategic Plans, Speeches from the Throne, and other documentation that provided information on CIC and Government of Canada priorities.

[1] Treasury Board Secretariat (2009) *Directive on the Evaluation Function.* http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=15681

***Legislative documents*:** including the *Immigration and Refugee Protection Act*, the *Immigration and Refugee Protection Regulations*, constitutional documents, *Canada Health Act*, *Quarantine Act*, Provincial Public Health Acts, and relevant international declarations and conventions.

***Program-specific documents*:** including:

- Modernized processing manuals and operation bulletins,
- Application kits, medical examination and assessment materials,
- Inter-departmental Memoranda of Understanding, operational and procedural reports/directives,
- Process maps, quality assurance documents,
- Provincial and Territorial public health and Tuberculosis priority and strategy documents,
- Public Health Agency of Canada's reports and publications related to conditions of significance to CIC/migration,
- Budgets and financial documents,
- Other documents available publically online and on the CIC intranet/internet site.

A full list of documents reviewed is provided in Section 2.0.

1.2.2. Literature Review

The evaluation reviewed over one hundred pieces of research, with close to 40 sources being used to directly inform various findings of the report. The literature review comprised of peer-reviewed journal articles gathered through comprehensive searches of various sources including:

- CIC's Reference Services Library;
- Google and Google Scholar portals;
- University of Ottawa Health Sciences Library;
- World Health Organization PLOS (Public Library of Science);
- CIC Health Branch and Research and Evaluation Branch; and
- Ad hoc requests through expert interviewees.

All documents were reviewed and the relevant information was extracted where it was identified to address specific evaluation questions and indicators. A secondary review of the extracted evidence was conducted in order to summarize the common/reappearing findings found in the relevant literature and to conduct a high-level analysis. The summary level findings were then grouped into three themes: 1) whether the findings supported the evaluation question or indicator; 2) whether the findings disagreed/disproved the question/indicator or where issues or gaps were identified; and 3) whether the findings provided suggestions or recommendations.

1.2.3. Key Informant Interviews{tc \l 1 "1.3 STRUCTURE OF THIS REPORT"}

Key informant interviews were used to gather qualitative information on all of the evaluation questions covering areas of program relevance and performance (see Section 3.0 for the interview guides). A total of 91 interviews were conducted either in-person or via telephone (see Table 1).[2] The list of interviewees was developed in consultation with the policy and program areas of CIC.

[2] Interviews involving multiple informants were treated as one response.

Table 1: Summary of Number of Interviews Conducted

Interview Group	Number
CIC National Headquarters Program Representatives	11
CIC Medical Officers	13
CIC Visa Office Staff	15
Canada Border Services Agency Representatives	5
Public Health Agency of Canada Representatives	4
Chief Medical Officers of Health (Provinces and Territories)	10
TB/Syphilis/HIV Provincial and Territorial Representatives	14
Panel Physicians	13
Experts in Migration Health	6
Total	**91**

The information gathered through the interviews was analysed by grouping thematic elements using NVivo Software. Where interview information is used in the report, it is presented using the scale shown in Table 2 below.

Table 2: Scale for the Presentation of Interview Results

All	Findings reflect the views and opinions of 100% of the interviewees.
Majority/Most	Findings reflect the views and opinions of at least 75% but less than 100% of interviewees.
Many	Findings reflect the views and opinions of at least 50% but less than 75% of interviewees.
Some	Findings reflect the views and opinions of at least 25% but less than 50% of interviewees.
A few	Findings reflect the views and opinions of at least two respondents but less than 25% of interviewees.

1.2.4. Country Comparison

A review of publicly available documents was conducted to examine the medical assessment process of Five Country Conference (FCC) partners (i.e., United States, United Kingdom, New Zealand, Australia) to gather information on similarities and differences between Canada's HSN Program and those in other similar immigrant receiving countries. Documents were reviewed and the relevant information was extracted where it was identified to address specific evaluation questions and indicators. Documents obtained from FCC government websites included:

- Annual reports;
- Strategic plans;
- TB technical instructions;
- Guidelines for TB control;
- Operational manuals; and
- Standing committee reports.

1.2.5. Stakeholder Surveys

Survey of CIC Visa Officers

The perspectives of CIC operational staff on the health screening component of the Program were sought through an online survey administered to 240 Canadian-based visa officers, including:

- Immigration Program Managers;
- Deputy Program Managers;
- Unit Supervisors;
- Senior Immigration Officers; and
- Immigration Officers.

The survey instrument (Section 5.1) was designed by the CIC Evaluation team and feedback was obtained from CIC's International Region. The survey instrument was pre-tested by the Deputy Program Managers in the missions that were visited during the site visits. Based on this feedback and knowledge gained through the site visits, the survey instrument was revised. The survey was administered by CIC's International Region on behalf of the CIC evaluation team. Potential survey respondents were sent an invitation email with a link to fill out the online survey in either English or French. The survey was carried out from April 2 to May 15, 2014 and 125 responses were received, for a response rate of 52% (the margin of error is ±6.08% using a 95% confidence level).

Figure 1: Response Rate for Visa Officer Survey, by Regional Medical Office

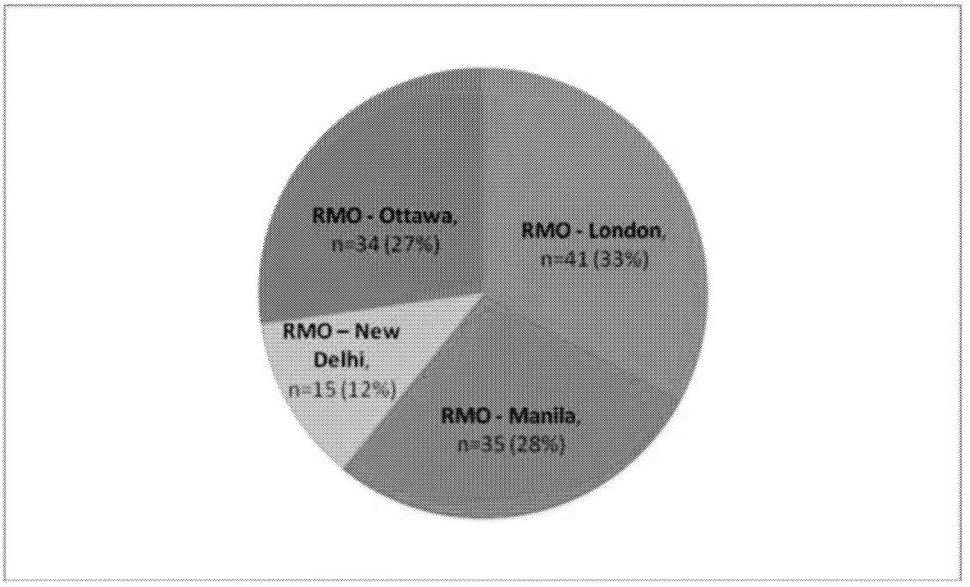
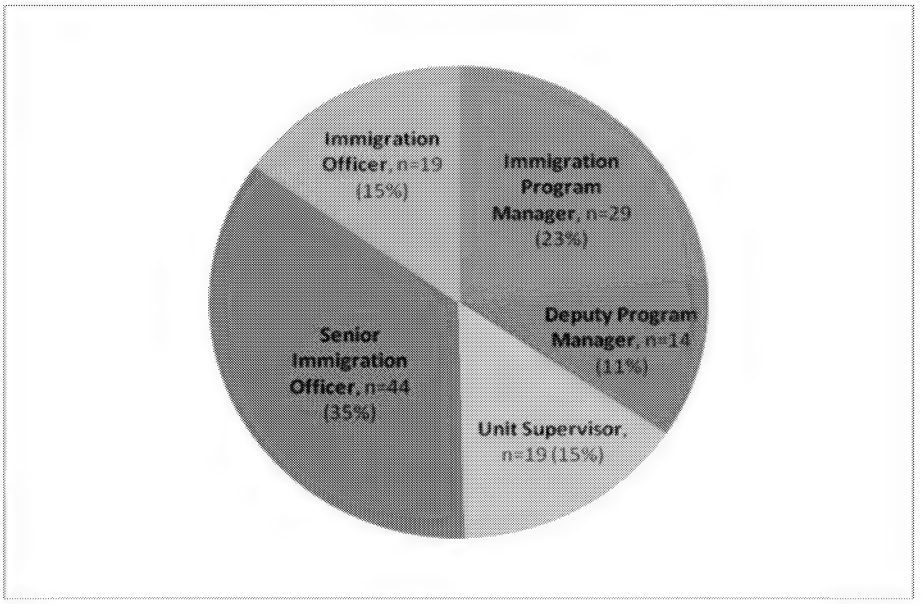


Figure 2: Response rate of Visa Officers by Position



Survey of Panel Physicians

An online survey (see Section 5.3 for survey instrument) of panel physicians was conducted between May 21 and June 30, 2015 to gather perspectives regarding their experience with Canada's Immigration Medical Examination (IME) process and to obtain their views on the information, tools, and support they receive from CIC.

CIC's four Regional Medical Offices (RMO) provided the evaluation team with a list of panel physicians who were active at the time of survey administration. The RMO sent an email communiqué to all active panel physicians in advance of the survey administration to inform them of the survey, encourage their participation, and ask for volunteers to pre-test the survey. Thirty-six panel physicians volunteered to pre-test the survey and 21 completed it and sent comments to the CIC evaluation team. The survey instrument was then refined based on the feedback received.

The on-line survey was sent to 904 panel physicians via an e-mail invitation. Panel physicians had the option of completing the survey in either English or French. A total of 521 responses were received for a response rate of 57.6% (the margin of error is ±2.80% using a 95% confidence level). Following the survey period, the evaluation team compared the respondent group to the known population and determined that it was representative, based on the RMO with which the panel physicians work (Table 3).

Table 3: Panel Physician Survey Responses compared to total number of Panel Physicians, by RMO

Regional Medical Office	Panel Physician List		Panel Physician Survey	
	Frequency	Percent	Frequency	Percent
RMO-London	314	34.7	192	36.9
RMO-Manila	236	26.1	114	21.9
RMO-New Delhi	116	12.8	64	12.3
RMO-Ottawa	238	26.3	151	29.0
Total	**904**	**100.0**	**521**	**100.0**

Survey of Provincial/Territorial Public Health Units

To evaluate the medical notification process and CIC's support of the surveillance process, a telephone survey in French or English was administered to Public Health Units (PHUs) that receive notifications of individuals who require medical surveillance (Section 5.5).[3]

Key issues covered by the telephone survey included:

- The effectiveness of the processes and tools that CIC has in place to help PHUs manage the notification process.
- The extent to which clients are complying with the surveillance requirement and perceptions on reasons why clients may not be complying.
- The impact of the surveillance program on the health of Canadians.

A telephone survey was chosen as the most appropriate surveying method given several constraints:

- Potential turnover and incomplete contact information for key representatives at all PHUs.
- Only having a general office phone number or email address attached to certain PHU offices.
- The varying methods P/Ts use to coordinate their surveillance programs (i.e., some P/T Ministries of Health handle all notifications and forward clients to PHUs, while others handle all notifications through their central health authority, including client reception). Due to these varying approaches, it was felt that a telephone would be most adaptable and flexible to ensuring that the right person is eventually surveyed.

To conduct the survey, the evaluation team contracted the services of a consulting firm, with expertise in survey administration. CIC provided the contractor with an initial list of PHU contacts which was then used to reach potential respondents and to book a suitable time to conduct the survey. During this stage, filter questions ensured that only PHU respondents who had recent experience with TB clients (i.e., in the last 5 years) were included in the survey.

Prior to its administration, the survey was field-tested in May 2014. In total, four pre-tests were completed with PHUs from Ontario. Due to some delays in obtaining and programming the French version of the survey, the field test was only conducted with English respondents. The survey instrument was finalized following the pre-test.

[3] Due to the approach for the notification process, not all PHUs were surveyed (i.e., some do not receive the notifications). In some cases, it was a representative of a P/T health authority that participated in the survey.

Out of 85 PHUs contacted, 55 PHU offices were surveyed (see Table 4, below). For several reasons, the full population of PHU offices could not be identified, with ensuring a representative sample being difficult to ensure. These reasons included:

- CIC's incomplete and outdated initial list of identified PHU contacts.
- The variation in approaches (i.e., centralized vs. decentralized) that various P/Ts use for handling notifications, which means different offices conduct slightly different types of work associated with receiving notifications and medical surveillance.
- The snowball sampling approach, which relied at times on initial calls and respondent-driven referrals, limited the ability to determine whether the survey holds an accurate reading of the target population.
- The sampling approach is likely to have decreased the randomness of the sample because certain P/Ts may be expected to have better integrated networks of PHU offices, which resulted in more accurate referrals.

For these reasons, a total response rate could not be calculated. However, the completion rate, based on the number of PHUs contacted and completed the survey is presented in the table below.

Table 4: Completion Rate of Public Health Unit Survey

Sample		Completions	
Province	**Number**	**Number**	**% of sample**
Alberta	2	1	50%
British Columbia	2	1	50%
Manitoba	3	2	67%
New Brunswick	7	7	100%
Newfoundland and Labrador	4	2	50%
Nova Scotia	5	3	60%
Nunavut	2	0	0%
Northwest Territories	1	0	0%
Ontario	39	27	69%
Prince Edward Island	1	0	0%
Quebec	16	10	63%
Saskatchewan	2	2	100%
Yukon	1	0	0%
Total	**85**	**55**	**65%**

1.2.6. Site Visits{tc \l 1 "1.3STRUCTURE OF THIS REPORT"}

Site visits were conducted to CIC's four RMOs in London, Delhi, Manila and Ottawa.[4] The site visits were designed to facilitate an understanding of the management and implementation of the Program, consistency in undertaking the Immigration Medical Examinations (IME) and the Immigration Medical Assessments (IMA), timeliness of decision-making, challenges with program delivery, and best practices. They also helped to inform the design of other data collection tools such as the survey of panel physicians, the CIC Visa Office survey, key informant interview process, and administrative data review. The site visit involved five main activities:

[4] The site visits were conducted during the following time periods: RMO-Americas (December 9-10, 2013); RMO-London (January 13-17, 2014); RMO-New Delhi (February 10-14, 2015); RMO-Manila (February 17-21).

1. **Process review / tour of operations,** involved a tour of the facilities with an emphasis on observing procedures related to the IME/IMA process. These tours provided contextual information that supported report writing and analysis.

2. **Interviews with locally engaged medical doctors and other locally engaged staff** in the RMOs. These interviews, which were assessed as part of the interview line of evidence, provided information related to the process for assessing IMEs and the management and operations of the RMO.

3. **Interviews with CIC Medical Officers in the RMOs.** These interviews, which were also assessed as part of the interview line of evidence, helped to inform program management and performance issues, including the effectiveness and efficiency of IMA processing.

4. **Interviews with Immigration Staff** who are involved in processing applications. These interviews, which also informed the interview methodology, provided input on program delivery, including challenges or issues related to assessing medical admissibility, impact of modernization initiatives (e-Medical), timeliness of decisions, and areas for improvement.

5. **Interviews with Panel Physicians** – These interviews helped to gain perspectives on the procedures, processes, and tools that CIC has developed for panel physicians and whether there are any gaps or improvements that are necessary.

1.2.7. Analysis of Program Data

Administrative data from CIC's Global Case Management System (GCMS), Field Operations Support System (FOSS), Immigrant Medical System (IMS),[5] Migration Health Branch annual and quarterly reports, and the Medical Surveillance Unit Client Manager (MSUCM)[6] were used to assess trends and outcomes of IMAs and surveillance notifications, over the evaluation period. The data was further assessed by RMO offices, immigration categories, types of medical conditions, and nature of inadmissibility encountered. GCMS data was also used to gather information on medical assessment processing times.

In addition, the evaluation used budgetary information from CIC's annual Reports on Plans and Priorities, Departmental Performance Reports, and cost data from CIC's Cost Management Model (CMM) to review the efficiency and economy of the HSN Program.

[5] IMS is the system that was used to collect information for the health screening component prior to the implementation of GCMS in 2012.
[6] The MSUCM database tracks all data related to the medical surveillance notification component.

2.0 Document Review

2.1. Document Review – Relevant Documents

Department of Justice

--Constitution Acts, 1867 to 1982. Retrieved from http://laws-lois.justice.gc.ca/eng/Const/page-4.html

---1996. Department of Health Act, (S.C. 1996, c. 8). Retrieved from http://laws-lois.justice.gc.ca/eng/acts/H-3.2/FullText.html

---2001. Immigration and Refugee Protection Act (S.C. 2001, c. 27). Retrieved from http://laws-lois.justice.gc.ca/eng/acts/I-2.5/page-1.html

---2002. Immigration and Refugee Protection Regulations (SOR/2002-227). Retrieved from http://laws-lois.justice.gc.ca/eng/regulations/SOR-2002-227/index.html

---2005. Quarantine Act (S.C. 2005, c. 20). Retrieved from http://laws-lois.justice.gc.ca/eng/acts/Q-1.1/index.html

Citizenship and Immigration Canada

---Medical Requirements. Retrieved from http://cicintranet.ci.gc.ca/connexion/tools-outils/medic/index-eng.aspx

---ENF 2/OP 18 Evaluating Inadmissibility - Medical inadmissibility.

---ENF 4 Port of Entry Examinations - Disembarkation and Roving Teams (DART).

---1997. Memorandum of Understanding between the International Organization for Migration and Citizenship and Immigration Canada.

---2008. Annual Report to Parliament on Immigration, 2008. Retrieved from http://www.cic.gc.ca/english/resources/publications/annual-report2008/index.asp

---2008. Departmental Performance Report For the period ending March 31, 2008. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/inst/imc/imc-eng.pdf

---2008. Memorandum of Understanding between the Public Health Agency of Canada and Citizenship and Immigration Canada.

---2008-2009. Report on Plans and Priorities 2008-2009. Retrieved from http://www.tbs-sct.gc.ca/rpp/2008-2009/inst/imc/imc-eng.pdf

---2009. Annual Report to Parliament on Immigration, 2009. Retrieved from http://www.cic.gc.ca/english/resources/publications/annual-report2009/index.asp

---2009. Departmental Performance Report For the period ending March 31, 2009. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2008-2009/inst/imc/imc-eng.pdf

---2009-2010. Report on Plans and Priorities 2009-2010. Retrieved from http://www.tbs-sct.gc.ca/rpp/2009-2010/inst/imc/imc-eng.pdf

---2010. Annual Report to Parliament on Immigration, 2010. Retrieved from http://www.cic.gc.ca/english/pdf/pub/immigration2010_e.pdf

---2010. Departmental Performance Report For the period ending March 31, 2010. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2009-2010/inst/imc/imc-eng.pdf

---2010-2011. Report on Plans and Priorities 2010-2011. Retrieved from http://www.tbs-sct.gc.ca/rpp/2009-2010/inst/imc/imc-eng.pdf

---2011. Annual Report to Parliament on Immigration, 2011. Retrieved from http://www.cic.gc.ca/english/pdf/pub/annual-report-2011.pdf

---2011. Departmental Performance Report For the period ending March 31, 2011. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2010-2011/inst/imc/imc-eng.pdf

---2011. Operational Bulletin 340 - Mandatory Referral to Canadian Public Health Authorities for Complex Pulmonary Tuberculosis-Inactive and other Non-infectious Communicable Diseases Cases.

---2011-2012. Report on Plans and Priorities 2011-2012. Retrieved from http://www.tbs-sct.gc.ca/rpp/2011-2012/inst/imc/imc-eng.pdf

--- 2011. Strategic Plan 2010-2015, 2011 Update.

---2012. Annual Report to Parliament on Immigration, 2012. Retrieved from http://www.cic.gc.ca/english/resources/publications/annual-report-2012/index.asp

---2012. Departmental Performance Report For the period ending March 31, 2012. Retrieved from http://www.cic.gc.ca/english/resources/publications/dpr/2012/dpr.asp

---2012. Facts and Figures.

---2012. OP 15 Medical Procedures.

---2012. Operational Bulletin 471 – October 31, 2012 - Changes to the Immigration Medical Examination Process.

---2012-2013. Report on Plans and Priorities 2012-2013. Retrieved from http://www.tbs-sct.gc.ca/rpp/2012-2013/inst/imc/imc-eng.pdf

---2013. Annual Report to Parliament on Immigration, 2013. Retrieved from http://www.cic.gc.ca/english/resources/publications/annual-report-2013/index.asp

---2013. Departmental Performance Report for the period ending March 31, 2013. Retrieved from http://www.cic.gc.ca/english/resources/publications/dpr/2013/dpr.asp

--- 2013. Panel Members' HANDBOOK 2013. Retrieved from http://www.cic.gc.ca/english/resources/publications/dmp-handbook/

---2013. Strategic Plan 2010–2015, 2013 Update.

---2014. Program Delivery Update-Sept 17 2014 - Assessment of medical requirements for foreign workers 1 and 2.

Citizenship and Immigration Canada - Migration Health Branch

---2010. Presentation to BOC - eMedical Update - November 29, 2010.

---2011. Presentation to BOC - eMedical Update - June 27 2011.

--- 2011. Immigration Medical Examination, Assessment and Surveillance Notification – Performance Measurement Framework.

---2012. DIAC - Initiative Plan - Development of eMedical, Version 1.5, December 2012.

--- 2012. Quality Assurance Plan.

---2012. Presentation to BOC - eMedical Update – February 20 2012.

--- 2013. Presentation to BOC - eMedical Update - May 13 2013.

---2013. CIC-PHAC Data Holdings, Surveillance.

--- 2013. Book 2 Overview: Health Branch Challenges and Opportunities.

Citizenship and Immigration Canada – Public Health Agency of Canada

---2012-2013. DRAFT. Federal Task Force on Tuberculosis - Terms of Reference.

---2013. DG Theme Discussion on Data Holdings and Surveillance related to Infectious Diseases - Meeting Notes.

Citizenship and Immigration Canada and Five Country Conference Partners

---Intergovernmental Immigration and Refugee Health Working Group (IIRHWG) – IIRWHG - Joint Priorities - Performance Measurement Framework.

Health Canada

---2012. Canada Health Act Annual Report 2012-2013. Retrieved from http://hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2013-cha-lcs-ar-ra/index-eng.php

---2013. Health Concerns – Tuberculosis. Retrieved from http://www.hc-sc.gc.ca/hc-ps/dc-ma/tuberculos-eng.php

International Organisation for Migration

http://www.canada.iom.int/

http://www.iom.int/cms/assessments-and-travel-assistance

---2012. Annual Report on Migration Health. Retrieved from http://publications.iom.int/bookstore/free/MHD_AR_2012_11Sept2013.pdf

Migration Policy Institute

Programs – International Migration Statistics. Retrieved from http://www.migrationpolicy.org/programs/data-hub/international-migration-statistics

Office of the Auditor General of Canada

---2011. 2011 Fall Report of the Auditor General of Canada - Chapter 2 Issuing Visas. Retrieved from http://www.oag-bvg.gc.ca/internet/docs/parl_oag_201111_02_e.pdf

Parliament of Canada
---1991. Immigration: Constitutional Issues. Retrieved from http://www.parl.gc.ca/Content/LOP/researchpublications/bp273-e.htm

---2004. Bill C-12: The Quarantine Act. Retrieved from http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?Language=E&ls=C12&Mode=1&Parl=38&Ses=1&source=library_prb

Public Health Agency of Canada

---2004. Governance and Organization of Public Health in Canada. Retrieved from http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/3-eng.php#s3b1

---2007. Strategic Plan 2007-2012 - Information, Knowledge, Action. Retrieved from http://www.phac-aspc.gc.ca/publicat/2007/sp-ps/pdfs/PHAC_StratPlan_E_WEB.pdf

---2008. Canadian Guidelines on Sexually Transmitted Infections. Retrieved from http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-6-1-eng.php

--- 2009. 2008-09 Departmental Performance Report. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2008-2009/inst/ahs/ahs01-eng.asp#_Toc240550396

---2009. Canadian Tuberculosis and Air Travel Guidelines, Version 2.0 (Effective June 2009). Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/pdf/guideform_tbaircraft09-eng.pdf

---2009. Population-Specific HIV/AIDS Status Report: People from Countries where HIV is Endemic - Black people of African and Caribbean descent living in Canada. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/africacaribbe/index-eng.php

--- 2010. 2009-10 Departmental Performance Report. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2009-2010/inst/ahs/ahs00-eng.asp

--- 2010. Tuberculosis in Canada 2010, Pre-Release . Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan10pre/index-eng.php

---2011. 2010-2011 Departmental Performance Report. Retrieved from http://www.tbs-sct.gc.ca/dpr-rmr/2010-2011/inst/ahs/ahs01-eng.asp#Str

--- 2012. 2011-2012 Departmental Performance Report. Retrieved from http://www.cic.gc.ca/english/resources/publications/dpr/2012/dpr.asp

--- 2012. At a Glance - HIV and AIDS in Canada: Surveillance Report to December 31st, 2012. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2012/dec/index-eng.php

--- 2012. Fact Sheet: People from Countries Where HIV/AIDS is Endemic. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/pr/sec8-eng.php

---2012. International Tuberculosis Incidence Rates. Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/itir-eng.php

---2012. Tuberculosis: Drug Resistance in Canada – 2012. Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tb-dr2012/index-eng.php

---2012. Tuberculosis in Canada 2012, Pre-Release. Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan12pre/index-eng.php

---2013. 2012-2013 Departmental Performance Report. Retrieved from http://www.phac-aspc.gc.ca/about_apropos/dpr-rmr/2012-2013/assets/pdf/dpr-rmr-2012-2013-eng.pdf

--- 2013. The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013: Infectious Disease - The Never-ending Threat. Retrieved from http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2013/assets/pdf/2013-eng.pdf

---2013. Framework for Action on Tuberculosis Prevention and Control, OGD Engagement. Presentation, March 2013.

--- 2014. Tuberculosis Prevention and Control in Canada-A Federal Framework for Action. Retrieved from http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tpc-pct/assets/pdf/tpc-pcta-eng.pdf

--- 2014. Canada Communicable Disease Report, Highlights of the new 7th edition of the Canadian Tuberculosis Standards. Volume 40-6, March 20, 2014. Retrieved from http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/14vol40/dr-rm40-06/dr-rm40-06-tub-eng.php

Public Health Agency of Canada Partnerships

Public Health Agency of Canada and Canadian Lung Association/Canadian Thoracic Society. 2007. Canadian Tuberculosis Standards, 6th Edition – 2007.

Pan-Canadian Public Health Network. 2012. Guidance for Tuberculosis Prevention and Control Programs in Canada.

Public Health Agency of Canada, and the Canadian Lung Association/Canadian Thoracic Society. 2014. Canadian Tuberculosis Standards, 7th edition - 2014.

Public Health Agency of Canada Centre for Communicable Diseases and Infection Control - Working Group

---2012. Tuberculosis Task Group (TB-TG) - Terms Of Reference.

--- 2014. TB and Migrants Working Group - Terms Of Reference – September 8, 2014.

United Nations

--- Department of Economic and Social Affairs. 2013. Number of International Migrants Rises above 232 million.

World Health Organisation

---2006. The Stop TB Strategy - Building on and enhancing DOTS to meet the TB-related Millennium Development Goals. Retrieved from http://www.who.int/tb/publications/2006/who_htm_tb_2006_368.pdf

---2007. International Health Regulations (IHR). Retrieved from http://www.who.int/topics/international_health_regulations/en/

---2009. The Global Plan to Stop TB 2006-2015: Progress Report 2006-2008 - Actions for life: building a successful future together.

---2011. Stop TB Partnership-Targets. Retrieved from www.stoptb.org

---2014. Incidence of Tuberculosis (per 100,000 people). Global Tuberculosis Report. Retrieved from http://data.worldbank.org/indicator/SH.TBS.INCD

---2014. Tuberculosis Fact Sheet. Retrieved from http://www.who.int/mediacentre/factsheets/fs104/en/

2.2. Citizenship and Immigration Canada's Health Screening and Notification Program Procedural Documents

Health Screening	
Stakeholder Group	**Document**
Regional Medical Offices	• Co-Management Framework – Management of Regional Medical Offices (2015) • Delegation of Authority and Immigration Medical Assessment Instructions (IMAIs) • 2011-12 Annual Regional Medical Officer Appraisal - Standard Appraisal Objectives, 2011
Medical Officers	• 1992. Handbook for Medical Officers Chapters 1 to 5.
Panel Physicians/ Members – Management	• 2009. Handbook for Designated Medical Practitioners. • 2013. Panel Members' Handbook 2013. • 2012. Operational Guideline for Designating Panel Radiologists. • 2013. Operational Guideline for Designating Panel Physician. • 2013. Operational Guideline for Confirming a Panel Member's Locum Tenens.
Panel Physicians/ Members – Management *Evaluation Tools for Duty Travel*	• Trip Report Template and Guide for RMOs. • 2011. Memo: PP Onsite Visit Tool. • 2011. Memo: Trip Report Template. • 2012. Duty Travel Report. • 2013. Panel Radiologist (PR) Audit Form. • 2013. Panel Physician (PP) Audit Form.
Panel Physicians/ Members – Management *Quality Control and Complaints Management*	• Letter for Invalid IME. • Letter for Resignation from Program. • Letter for Change of City. • 2013. Operational Guideline for Panel Member Management: QA Concerns, Complaints and Appeals. • 2014. Assessing non-medical information submitted in response to a procedural fairness letter regarding possible medical inadmissibility.
Panel Physicians - Immigration Medical Examinations	• Acknowledgement of the Automatic Partner Notification Policy for HIV Applicants in the Family or Dependant Refugee Classes of the Department of Citizenship and Immigration Canada (CIC). • ANNEX 9: Refusal Letter for Sponsorship Withdrawal in the Family Class - (April 28 regs). • Declaration of Ability and Willingness. • Interpreter Declaration of an Oral/Written Statement. • Instructions for requesting a medical reassessment. • Instructions related to Procedural Fairness (danger to public health and public safety). • Instructions for procedural fairness – Excessive Demand. • Letter to Medical Officer (from Visa/Immigration Officer) about New Medical Information in Procedural Fairness Cases. • Medical Examination Instructions. • Notification to Spouse/Partner of the Applicant's HIV-Positive Status in the Familly and Dependant Refugee Classes. • Procedural fairness Letter - Medical inadmissibility - Excessive demand. • 2012. Health Follow-Up Handout: HIV Infection (for applicant). • 2012. IMM 5743E - Client Consent and Declaration. • 2013. Evaluating Temporary Resident Applications for Medical Treatment. • 2013. HIV Contact Information in Canada (for sponsor). • 2013. Regulatory Definitions Related to Excessive Demand.

	• 2013. Automatic Partner Notification Policy for Human Immuno-Deficiency Virus (HIV) Positive Applicants in the Family and Dependant Refugee Classes. • 2014. Assessing non-medical information submitted in response to a procedural fairness letter regarding possible medical inadmissibility (available internally only). • 2014. Completing the IMM 0535 form for cases requiring medical surveillance by the provincial or territorial public health authorities. • 2014. Medical assessment coding. • 2014. Process for medical refusals. • 2014. Results of the immigration medical examination – Syphilis screening.
Panel Physicians - Immigration Medical Examinations *IME Instructions*	• Immigration Medical Examination Instructions - Activities of Daily Living Assessment - IMM 5725. • Immigration Medical Examination Instructions - Assessment of Cognitive Functioning. • Immigration Medical Examination Instructions - Body mass index. • Immigration Medical Examination Instructions - Breast examination. • Immigration Medical Examination Instructions - Cancer or malignancy. • Immigration Medical Examination Instructions - Cardiac disease. • Immigration Medical Examination Instructions - Cognitive impairment in adults. • Immigration Medical Examination Instructions - Debilitating conditions. • Immigration Medical Examination Instructions - Developmental delay in children. • Immigration Medical Examination Instructions - Developmental milestones Chart of early childhood development - IMM 5738. • Immigration Medical Examination Instructions – Diabetes. • Immigration Medical Examination Instructions - Hearing impairment or deafness. • Immigration Medical Examination Instructions - Height/ weight/head circumference percentile for children. • Immigration Medical Examination Instructions - Hepatitis / liver disease. • Immigration Medical Examination Instructions - HIV screening. • Immigration Medical Examination Instructions - Hypertension. • Immigration Medical Examination Instructions - Global assessment of function - IMM 5727. • Immigration Medical Examination Instructions - Psychiatric Conditions (Depressive disorders, psychosis and substance – related disorders). • Immigration Medical Examination Instructions - Renal disease. • Immigration Medical Examination Instructions - Resettlement needs assessment - IMM 5544. • Immigration Medical Examination Instructions - Serum Creatinine. • Immigration Medical Examination Instructions - Syphilis screening and management. • Immigration Medical Examination Instructions - Tuberculosis. • Immigration Medical Examination Instructions - Urinalysis.

Surveillance Documents
• Medical Surveillance Handouts: Tuberculosis. • 2003. IMM 5365 - Medical Notification. • 2009. Guidelines for Complex Pulmonary Tuberculosis Inactive (PTI) and Other Complex, Non-Infectious Tuberculosis Cases requiring Urgent Referral to Provincial/Territorial Public Health Authorities. • 2009. IMM 0535 - Medical Surveillance Undertaking. • 2011. Medical Surveillance Handout: Syphilis. • 2014. Program delivery update – Terms and conditions of entry and medical surveillance for individuals with a positive screening test for syphilis.

Quality Assurance Documents

- IME Assessment Concurrence.
- Complaint Logbook.
- Data Entry QA of Paper-Based IMEs into GCMS.
- Data entry QA of compliance reporting and data entry QA of surveillance forms into MSUCM.
- QA reports included in post eMedical implementation plan.
- Chest X-Ray grading verification.
- 2011. Memorandum of Understanding between the Commonwealth of Australia and the Government of Canada in relation to Medical Examiner Quality Assurance Information.
- 2013. Dispensation Requests - Service Standards QA Tool.
- 2013. Duty travel reporting December 2012.
- 2013. Propose a standardized Sampling Methodology for Health Branch Quality Assurance Activities.
- 2013. QA SOP 1.1 - Quality Assurance Standard Operating Procedure - Report on service standards for responding to dispensation requests.
- 2013. QA SOP 1.2 - Quality Assurance Standard Operating Procedure - Report on service standards for responding to complaints.
- 2013. QA SOP 1.3 - Quality Assurance Standard Operating Procedure - Report on duty travel (service standards and quality standards).
- 2013. QA SOP 1.4 - Quality Assurance Standard Operating Procedure - Report on the quality of Panel Member files for completeness.
- 2013. QA SOP 2.1 - Quality Assurance Standard Operating Procedure - Report on service standards for Panel Physician processing times.
- 2013. QA SOP 2.2 - Quality Assurance Standard Operating Procedure - Report on IMEs that are missing the client's consent.
- 2013. QA SOP 2.3 - Quality Assurance Standard Operating Procedure - Report on quality of compliance with mandatory tests.
- 2013. QA SOP 2.4 - Quality Assurance Standard Operating Procedure - Report on concurrence with Panel Radiologist x-ray gradings.
- 2013. QA SOP 2.5 - Quality Assurance Standard Operating Procedure - Report on Files with identity concerns flagged by Panel Members.
- 2013. QA SOP 2.6 - Quality Assurance Standard Operating Procedure - Report on complaints received about Panel Members.
- 2013. QA SOP 2.7 - Quality Assurance Standard Operating Procedure - Report on Panel Member errors.
- 2013. QA SOP 3.1 - Quality Assurance Standard Operating Procedure - Report on service standards for finalizing cases.
- 2013. QA SOP 3.2 - Quality Assurance Standard Operating Procedure - Report on the quality of manual data entry of paper-based IMEs into GCMS.
- 2013. QA SOP 3.3 - Quality Assurance Standard Operating Procedure - Report on respecting the delegation of authority to finalize cases.
- 2013. QA SOP 3.4 - Quality Assurance Standard Operating Procedure - Report on IMA concurrence.
- 2013. QA SOP 3.5 - Quality Assurance Standard Operating Procedure - Report on files on hand (received and in progress/review required).
- 2013. QA SOP 4.1 - Quality Assurance Standard Operating Procedure - Report on service standards regarding notifications to PHAs.
- 2013. QA SOP 4.2 - Quality Assurance Standard Operating Procedure - Report on service standards regarding response to provincial requests.
- 2013. QA SOP 4.3 - Quality Assurance Standard Operating Procedure - Report on quality of data entry by PHLU staff.
- 2013. QA SOP 4.4 - Quality Assurance Standard Operating Procedure - Report on the quality of compliance reporting in the electronic systems.
- 2013. QA SOP 4.5 - Quality Assurance Standard Operating Procedure - Report on timelines for compliance with

surveillance.

- 2013. QA SOP 4.6 - Quality Assurance Standard Operating Procedure - Report on clients landed that require medical surveillance.
- 2013. Revised Service Standards and Quality Standards.

2.3. Provincial and Territorial Reviewed Resources

ALBERTA

--- 2012. Speech from the Throne – May 2012. Retrieved from http://alberta.ca/thronespeech2012may.cfm

---2014. Budget Highlights 2014. Retrieved from http://alberta.ca/budget-highlights.cfm#health

Ministry of Health

---2014. Annual Report 2013-14. Retrieved from http://www.health.alberta.ca/documents/Annual-Report-14.pdf

---2013. Health Care Cost Drivers. Retrieved from http://www.health.alberta.ca/documents/Health-Care-Cost-Drivers-Alberta-2013.pdf

---2015. Public Health Act (Revised Statutes of Alberta 2000 - Chapter P-37. Retrieved from http://www.qp.alberta.ca/documents/acts/p37.pdf

BRITISH COLUMBIA

---Public Health Act. Retrieved from http://www.bclaws.ca/civix/document/id/complete/statreg/08028_01#division_d2e1465

---2014. Budget Speech 2014. Retrieved from http://bcbudget.gov.bc.ca/2014/speech/2014_Budget_Speech.pdf

Ministry of Health

---BC Strategic Plan for Tuberculosis Prevention, Treatment and Control. Retrieved from http://www.search.e-laws.gov.on.ca/en/isysquery/de659029-935e-4b0b-8a15-b7e7af67acf2/9/doc/?search=browseStatutes&context=#hit1

---2013. 2012/13 Annual Service Plan Report. Retrieved from http://www.bcbudget.gov.bc.ca/Annual_Reports/2012_2013/pdf/ministry/hlth.pdf

MANITOBA

---2006. The Public Health Act (C.C.S.M. c. P210). Retrieved from http://web2.gov.mb.ca/laws/statutes/ccsm/p210e.php

--- 2013. Speech from the Throne at the Opening of the Third Session of the 40th Legislature of the Province of Manitoba. Retrieved from http://www.gov.mb.ca/thronespeech/thronespeech_2013.html

Ministry of Health

--- Message from the Minister of Health. Retrieved from http://www.gov.mb.ca/health/minister.html

NEW BRUNSWICK

---1998. Public Health Act (S.N.B. 1998, c. P-22.4). Retrieved from http://laws.gnb.ca/en/showfulldoc/cs/P-22.4//20150122

---2013. Budget addresses deficit and economy through balanced approach. Retrieved from http://www2.gnb.ca/content/gnb/en/news/news_release.2013.03.0255.html

Ministry of Health

---Rebuilding Health Care together - The Provincial Health Plan 2013-2018. Retrieved from http://www.gnb.ca/0212/values/pdf/9129%20english.pdf

NEWFOUNDLAND AND LABRADOR

---2003. Department of Health and Community Services Notice, 2003 under the Executive Council Act (O.C. 2003-370). Retrieved from http://www.assembly.nl.ca/legislation/sr/regulations/rc030082.htm

---2013. Budget 2013 Delivers on Provincial Government's Commitment to Health Care. Retrieved from http://www.releases.gov.nl.ca/releases/2013/health/0401n05.htm

---2012. Responsible Investments Enhance Health Care Services for Newfoundlanders and labradorians. Retrieved from http://www.releases.gov.nl.ca/releases/2012/health/0424n09.htm

Department of Health

--- 2006. Minister provides Quarterly Update on Wait times for health Care Procedures . Retrieved from http://www.releases.gov.nl.ca/releases/2006/health/1221n06.htm

NORTHWEST TERRITORIES

---2009. Public Health Act (S.N.W.T. 2007, c.17 -SI-007-2009). Retrieved from https://www.canlii.org/en/nt/laws/stat/snwt-2007-c-17/latest/part-1/snwt-2007-c-17-part-1.pdf

---2011. Building on our Foundation 2011-2016 - A strategic plan for the NWT Health and Social Services System. Retrieved from http://www.hss.gov.nt.ca/sites/default/files/building_on_our_foundation.pdf

---2011. Northwest Territories Health Programs and Services – 2011 - Department of Health and Social Services. Retrieved from http://www.hss.gov.nt.ca/sites/default/files/nwt_201103_e_34998.pdf

NOVA SCOTIA

---2004. Health Protection Act (Chapter 4 of the Acts of 2004). Retrieved from http://nslegislature.ca/legc/statutes/health%20protection.pdf

---2013. Putting Nova Scotians First - Speech from the Throne, November 2013. Retrieved from http://nslegislature.ca/pdfs/proceedings/ThroneSpeechNovember282013.pdf

Ministry of Health and Wellness

--- Annual Statement of Mandate for the Fiscal Year 2014-2015. Retrieved from http://novascotia.ca/dhw/corporate-reports/documents/DHW_Statement_of_Mandate_for_2014-2015.pdf

NUNAVUT

---1988. Public Health Act (R.S.N.W.T. 1988, c.P-12). Retrieved from http://www.justice.gov.nu.ca/apps/authoring/dspPage.aspx?page=CURRENT%20CONSOLIDATIONS%20OF%20ACTS%20AND%20REGULATIONS&letter=*

---2009. 2009-2010 Government of Nunavut Budget. Retrieved from http://gov.nu.ca/sites/default/files/files/Finance/Budgets/2009-10%20budgets/GNBudget09-10.pdf

ONTARIO
---Health Promotion and Protection Act - http://www.search.e-laws.gov.on.ca/en/isysquery/34e4d0b4-3c71-404a-93b0-43cec83b5d93/11/doc/?search=browseStatutes&context=#hit1

Ministry of Health and Long-Term Care
---2012. Ontario's Action Plan For Health Care. Retrieved from http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

---2013. Make no little plans - Ontario's Public Health Sector Strategic Plan. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/make_no_little_plans/docs/make_no_little_plans.pdf

---2014. Results-based Plan Briefing Book 2013-2014. Retrieved from http://health.gov.on.ca/en/common/ministry/publications/plans/rbplan13/

PRINCE EDWARD ISLAND
---1988. Public Health Act (R.S.P.E.I. 1988, Cap. P- 30.1). Retrieved from http://www.gov.pe.ca/law/regulations/pdf/P&30-1-05.pdf

---2009. Prince Edward Island Communicable Disease Report 2009. Retrieved from http://www.gov.pe.ca/photos/original/dohw_epi_cd2009.pdf

QUEBEC
---1991. Act Respecting Health Services and Social Services (chapter S-4.2). Retrieved from http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html

---2014. Discours d'ouverture de la 1re session de la 41e législature de l'Assemblée nationale du Québec. Retrieved from http://www.premier.gouv.qc.ca/actualites/allocutions/details.asp?idAllocutions=857

Ministère de la santé
---Guide d'intervention pour la tuberculose.

SASKATCHEWAN
---Public Health Act. Retrieved from http://health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=1414,94,88,Documents&MediaID=870&Filename=brief-orientation-pulbic-health-act.pdf&l=English

--- 2013. Saskatchewan Provincial Budget 2012-2013. Retrieved from http://www.finance.gov.sk.ca/budget2012-13/2012-13BudgetSummary.pdf

---2013. Speech from the Throne 2013. Retrieved from http://www.gov.sk.ca/throne-speech-2013-english.pdf

YUKON

---2002. Health Act (Revised statutes of the Yukon 2002 - Chapter 106 Health Act). Retrieved from http://www.gov.yk.ca/legislation/acts/health.pdf

---2009. The Yukon Health Care Review – Taking the pulse. Retrieved from http://www.gov.yk.ca/news/pdf/yukon_health_care_review_prelim_report.pdf

---2012. Budget Address 2012-2013. Retrieved from http://www.finance.gov.yk.ca/pdf/budget/2012_2013_speech_e.pdf

3.0 Interview Guides

3.1. Citizenship and Immigration Canada Senior Managers – National Headquarters

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe your role and responsibilities as they relate to the Health Screening and Notification (HSN) Program?

Program Relevance

2.

a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?

b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- Facilitating medical examinations and conducting assessments?
- Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Program Policy and Design

Applicants are screened for medical conditions, including active tuberculosis and untreated syphilis, which are deemed to be a danger to public health.

4.

a) Is the policy on danger to public health still needed and relevant? Why or why not?

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

Applicants are also screened for conditions which may pose a danger to public safety such as a variety of serious mental health conditions (e.g., sociopathic disorders, pedophilia, violent tendencies, etc.).

5.
a) Is the policy on danger to public safety still needed and relevant? Why or why not?
b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Applicants who are likely to impose a burden on Canadian health care or social services may be deemed inadmissible on 'Excessive Demand' if their health care expenditures are likely to be more than the Canadian average. Certain applicants such as refugees and sponsored spouses, partners, and children are also exempt from this regulation.

6. Is the policy on Excessive Demand still needed and relevant? Why or why not?

CIC screens certain applicants and populations for health-related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from examinations such as those typically visiting Canada for less than six months and those visiting Canada for longer than six months and coming from certain designated countries.

7. Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Management and Delivery

8. What changes have been made to the medical screening and notification program as a result of modernization?
   a) What has been the impact of modernization?
   b) Have there been any gaps or challenges?

9. Have there been any issues, challenges, or successful practices which have had an impact on the management, governance, or delivery of the HSN Program?

Program Performance

10. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?
    a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

11. To what extent has the HSN Program:
    a) Reduced the burden on the health and social services in Canada? Please explain.
    b) Protected the health and safety of Canadians? Please explain.

Resource Utilization

12. Have there been any changes to the program that have made operations more efficient?
    a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?
    b) Any suggestions to improve program efficiency?

13. Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?

Thank you for your time and cooperation.

3.2. Citizenship and Immigration Canada Staff – National Headquarters

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?

Program Relevance

2.
   a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?
   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

3. a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:
   - Facilitating medical examinations and conducting assessments?
   - Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

   b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Program Policy and Design

Applicants are screened for medical conditions, including active tuberculosis and untreated syphilis, which are deemed to be a danger to public health.

4.
   a) Is the policy on danger to public health still needed and relevant? Why or why not?
   b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

Applicants are also screened for conditions which may pose a danger to public safety such as a variety of serious mental health conditions (e.g., sociopathic disorders, pedophilia, violent tendencies, etc.).

5.

a) Is the policy on danger to public safety still needed and relevant? Why or why not?
b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Applicants who are likely to impose a burden on Canadian health care or social services may be deemed inadmissible on 'Excessive Demand' if their health care expenditures are likely to be more than the Canadian average. Certain applicants such as refugees and sponsored spouses, partners, and children are also exempt from this regulation.

6. Is the policy on Excessive Demand still needed and relevant? Why or why not?

CIC screens certain applicants and populations for health-related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from examinations such as those typically visiting Canada for less than six months and those visiting Canada for longer than six months and coming from certain designated countries.

7. Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Management and Delivery

8. What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?
   a) How effective are these tools, training, guidance, etc?
   b) Are any improvements required?

9. What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program?
   a) How effective are these tools, etc?
   b) Are any improvements required?

10. What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?
    a) How effective are these mechanisms?
    b) Are there any barriers?
    c) Are any improvements required?

11. What changes have been made to the medical screening and notification program as a result of modernization?
    a) What has been the impact of modernization?
    b) Have there been any gaps or challenges?

Program Performance

12. Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?
    a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?
    b) Do you have any suggestions to improve clients' awareness and compliance?

13. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?
    a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

14. To what extent has the HSN Program:
    a) Reduced the burden on the health and social services in Canada? Please explain.
    b) Protected the health and safety of Canadians? Please explain.

Resource Utilization

15. Have there been any changes to the program that have made operations more efficient?
    a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?
    b) Any suggestions to improve program efficiency?

16. Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?

Thank you for your time and cooperation.

3.3. Chief Medical Officers of Health (Provinces and Territories)

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you please describe your current role as it relates to health, immigration, or infectious diseases?

Program Relevance

2.
    a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?
    b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

3. *As you may be aware, the role of the federal government in the HSN Program is to facilitate medical examinations for clients through local panel physicians; conduct medical assessments for immigration purposes using the results of medical examinations; identify applicants who require medical surveillance in Canada; and notify provincial/territorial health authorities of the presence of individuals requiring surveillance.*

    a) Considering each of these federal responsibilities, is the federal government's current role appropriate:
    - In facilitating medical examinations and conducting assessments?
    - In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

Program Policy and Design

4. *The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis.*

    a) Is the policy on danger to public health still needed and relevant? Why or why not?
    b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

5. *CIC screens certain applicants and populations for health related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from medical examinations such as those typically visiting Canada for less than six months.*

a) Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Performance

6. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

   a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?
   b) Are there any data available on active TB cases within in the immigration population in your province or territory?
   c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

Resource Utilization

7. Are there any overall or general improvements to the HSN Program you would recommend?

Thank you for your time and cooperation.

3.4. Citizenship and Immigration Canada Staff – eMedical Staff

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe the function and mandate of the eMedical Unit? What is your role within the eMedical unit?

2. What was the rationale for developing and implementing the eMedical system?

3. In your opinion, has the eMedical system achieved its intended purpose and goals? What evidence would you point to that demonstrates this achievement? Please explain.

4. What challenges or successes have you encountered which have had an impact on the delivery of the eMedical system? Are there any improvements you would make?

5. What tools, training or guidance are available to support the delivery of the eMedical system?
    a) How effective are these tools, etc?
    b) Are any improvements required?

6. From your perspective, how well has the eMedical system been received by key stakeholders of the HSN Program (i.e., Panel Physicians, RMOs, Visa Officers)?

Thank you for your time and cooperation.

3.5. Centralized Processing Region Staff

1. Can you please describe how your CPC is involved in the Immigration Medical Examination (IME) and Surveillance Notification Process (i.e. providing the client with surveillance requirement form)?

2. What tools, training and guidance are available at your CPC to support the delivery of your role regarding IMEs and surveillance notification?
    a) How effective are these tools, etc?
    b) Are any improvements required?

3. Who do you communicate with regarding medical examination results? How effective is the information exchange?
    a) Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information?
    b) What would you recommend to improve the exchange of information?

4. Is the medical process clear for CPCs? Are there any gaps in the process that can result in people getting "missed" for a medical while inland, either when they extend, change their status, or become PR?
    a) Any suggested improvements?

5. How you know which clients require a medical exam? Are they any challenges in determining this?

6. Is there consistency in processing applications in CPR where medicals are concerned?

7. Are there any systems issues (i.e. GCMS) or other limitations/challenges in this process?

8. How do you inform a client that they require medical surveillance?
    a) Are there any gaps or challenges in this process?
    b) Do you have any suggestions to improve clients' awareness?

9. Do you have anything else to add?

3.6. Public Health Agency of Canada Representatives

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you please describe your area of expertise as it relates to migration health, immigration, or infectious diseases?

Program Relevance

2. Do you feel that the HSN Program aligns with the priorities of the Government of Canada and/or your departmental priorities? In what ways does the Program align/not align?

3.
    a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?
    b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

4. *The role of the federal government in the HSN Program is to facilitate medical examinations for clients through local panel physicians; conduct medical assessments for immigration purposes using the results of medical examinations; identify applicants who require medical surveillance in Canada; and notify provincial/territorial health authorities of the presence of individuals requiring surveillance.*

    a) Considering each of these federal responsibilities, is the federal government's current role appropriate:
    - In facilitating medical examinations and conducting assessments?
    - In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

    b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Program Policy and Design

5. *The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis.*

a) Is the policy on danger to public health still needed and relevant? Why or why not?
b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

6. *CIC screens certain applicants and populations for health related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from medical examinations such as those typically visiting Canada for less than six months.*

    a) Are we screening the right applicants and populations of applicants? Are there any gaps?

7. How does CIC engage PHAC with respect to issues related immigration and public health, and more specifically with respect to the HSN program?

    a) Is the nature and level of engagement appropriate?
    b) Are any improvements needed?

Program Performance

8. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

    a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?
    b) Are there any data available on active TB cases within in the immigration population in Canada?
    c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

9. To what extent has the HSN Program:

    a) Reduced the burden on the health and social services in Canada? Please explain.
    b) Protected the health and safety of Canadians? Please explain.

Thank you for your time and cooperation.

3.7. Canadian Border Services Agency Representatives

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you please describe how the medical notification program works at the Port of Entry?

Program Management and Delivery

2. What tools, training and guidance are available at CBSA to support the delivery of the Medical Notification component of the HSN Program?
    a) How effective are these tools, etc?
    b) Are any improvements required?

Program Performance

3. How effective is the information exchange (e.g., sending IMM0535s) between CBSA and CIC?
    a) Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information between CBSA and CIC? What are they? Are the established standards being followed?
    b) What would you recommend to improve the exchange of information between CBSA and CIC?

4. Are clients being effectively and consistently informed of their responsibilities for surveillance at POEs?
    a) What challenges does CBSA encounter in making sure that individuals understand their medical condition and comply with surveillance requirements?
    b) Are there any gaps in the information they receive?
    c) Do you have any suggestions to improve clients' awareness and compliance?

Program Relevance

5. Do you feel that the HSN Program aligns with the priorities of the Government of Canada? In what ways does the Program align/not align?

6. Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Thank you for your time and cooperation.

3.8. TB/Syphilis/HIV Provincial and Territorial Representatives

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you please describe your current role as it relates to health, immigration, or infectious diseases?

Program Relevance

2.
   a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?
   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

3. *As you may be aware, the role of the federal government in the HSN Program is to facilitate medical examinations for clients through local panel physicians; conduct medical assessments for immigration purposes using the results of medical examinations; identify applicants who require medical surveillance in Canada; and notify provincial/territorial health authorities of the presence of individuals requiring surveillance.*

   a) Is the federal government's current role appropriate in terms of identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

Program Policy and Design

4. *The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis.*

   a) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

5. *CIC screens certain applicants and populations for health related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from medical examinations such as those typically visiting Canada for less than six months.*

   a) Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Management and Delivery

6. Can you please describe how the notification and surveillance process works in your province or territory, including any communication and coordination mechanisms in place to engage with CIC regarding this process?

7. What tools, training, and/or guidance have been provided by CIC to help facilitate the notification/surveillance process?

8. How well does the notification/surveillance process function in your province/territory, including the communication/coordination mechanisms in place and any tools, training, or guidance you may have received?

    a) Are there any issues or challenges which have had an impact on this process?
    b) Are any improvements necessary?

Program Performance

9. Are there any standards in place (i.e., regarding timeliness and accuracy of information) to facilitate the exchange of information between your province or territory and CIC? Are the established standards being followed?

10. To what degree are clients in your province/territory compliant with their surveillance conditions?

    a) What are some of the reasons why clients might not be complying with the surveillance requirements (i.e., complexity of requirements and their level of understanding)?

11. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

    a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?
    b) Are there any data available on active TB cases within in the immigration population in your region?
    c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

Other

12. Are there any overall or general improvements to the HSN Program you would recommend?

13. As part of this evaluation, we are planning to conduct a survey of Public Health Units (PHUs) across Canada to gather their views on the HSN Program. Would you be able to provide us with a list of the PHU representatives in your province who we would be able to respond to a survey with respect to the surveillance / notification process for TB?

Thank you for your time and cooperation.

3.9. Experts in Migration Health

The Evaluation Division of Citizenship and Immigration Canada is currently conducting an evaluation of the Health Screening and Notification (HSN) Program. This is a program, within Citizenship and Immigration Canada (CIC), which is charged with responsibilities including: the medical screening of certain visa applicants overseas; and, the notification to provinces and territories of public health risks. The purpose of this evaluation is to examine issues related to program relevance, program management and delivery, and program performance.

As a key support to documentary evidence, the evaluation team is conducting interviews with both internal and external stakeholders involved in the Program; we have included subject matter experts, such as yourself, in order to ensure that our understandings of the background themes within this complex subject matter are accurate. Please find a small annex included with this interview guide; it provides some key definitions and descriptions of policy. You may find this helpful to inform your comments. Please note, it is not expected that you will respond to all questions.

The evaluation will cover program activities from 2008/09 to 2012/13; however, please share any key background that falls outside this time frame. The following questions will serve as a guide for the interview, and your responses may be probed to assist in a deeper contextual understanding. Please note that the responses you provide are confidential and will not be attributed to you in the evaluation report or in any documentation. Only aggregate information will be released.

1. Please describe your area of expertise as it relates to migration health, immigration or infectious diseases.

2. Please describe your familiarity with the Health Screening and Notification Program.

3. In your expert opinion, what are some of the key studies in your field that explore themes related to Canadian medical screening and specific diseases (i.e. tuberculosis, syphilis)?

    a) Can you comment on any best practices in your field that could guide our research in this subject matter area?
    b) Are there any recently produced pieces of research that provide innovative perspectives on your subject matter area?

Program Relevance

4. Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?

    a) Have you noticed any global trends related to the incidence of health conditions relevant to the immigration context?

5. Should applicants with health conditions deemed to be of public health significance (i.e. tuberculosis, syphilis) require medical surveillance on arrival?

Program Design

6. The current CIC policy with respect to screening applicants for conditions that impact public health is described in the accompanying annex; please review this description in order to comment.

7. Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

8. The current CIC policy with respect to screening applicants for conditions that impact public safety is described in the accompanying annex; please review this description in order to comment.

9. Are we considering the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

10. Canada also screens people to determine whether they would place an "excessive demand" on the health system. Please see the accompanying annex for a definition of "excessive demand".

11. Can you comment on whether the policies related to excessive demand are still needed and relevant? Why or why not?

12. According to the existing body of research, are the applicants and populations we currently screen the right ones to focus on?

13. Are there certain populations/geographic areas that available research/literature has illustrated a need to focus on?

14. What is the prevalence of the chronic conditions we screen for in immigrant populations compared to non-immigrant populations? Are the conditions we screen for the ones with the highest prevalence among the populations we are concerned with?

Program Performance

15. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?

    a) Are there any gaps in CIC's health screening approach that affects the identification of these clients?

16. To what extent has the HSN Program:

    a) reduced the burden on health and social services in Canada? Please explain.
    b) protected the health and safety of Canadians? Please explain.
    c) Are there any other benefits of the program to Canada?

Resource Utilization

17. Can you comment on the cost savings to the Canadian health system that results from treating active TB to completion? How many cases of active TB get treated in Canada each year?

Other

18. Are there other responsibilities that should be a part of the federal role in this area? If so, what are they and why should they be a federal responsibility?

19. Is there anything you would like to add?

Thank you for your time and cooperation.

4.0 Country Comparison – Reviewed Documents / Resources

AUSTRALIA

---2012. "Policy and Guidelines: The Strategic Plan for Control of Tuberculosis in Australia 2011-2015". Retrieved from http://www.health.nsw.gov.au/Infectious/tuberculosis/Documents/strategic-plan-2011-2015.pdf

---2012. "Australian Government Response to the Joint Standing Committee on Migration report: Enabling Australia - Inquiry into the Migration Treatment of Disability". Retrieved from https://www.immi.gov.au/media/publications/pdf/2012/joint-standing-comm-enabling-australia.pdf

---2014. "Health Examinations". Retrieved from https://www.immi.gov.au/allforms/health-requirements/health-exam.htm

Australia, Department of Immigration and Border Protection

--- "Arranging a Health Examination". Retrieved from http://www.immi.gov.au/allforms/health-requirements/arranging-health-exam.htm

---"Fact Sheet 22 -The Health Requirement". Retrieved from http://www.immi.gov.au/media/fact-sheets/22health.htm

---"Health Requirement for Permanent Entry to Australia - Form 1071i". Retrieved from https://www.immi.gov.au/allforms/pdf/1071i.pdf

---"Health Undertakings". Retrieved from https://www.immi.gov.au/allforms/health-requirements/health-undertakings.htm

---"Threats to Public Health". Retrieved from http://www.immi.gov.au/allforms/health-requirements/threats-public-health.htm

---1999. "Migration (Health Services) Charge Act 1991 (Act No. 197 of 1991 as amended)". Retrieved from http://www.comlaw.gov.au/Details/C2004C00444

---2012. "Migration Act 1958 (Act No. 62 of 1958 as amended)". Retrieved from http://www.comlaw.gov.au/Details/C2012C00331

--- 2013. "Annual Report 2012-13". Retrieved from http://www.immi.gov.au/about/reports/annual/2012-13/pdf/2012-13-diac-annual-report.pdf

---2015. "Medical Examinations for an Australian Visa – Form 26". Retrieved from http://www.immi.gov.au/allforms/pdf/26.pdf

Parliament of the Commonwealth of Australia

---2010. "Chapter 3: The Migration Health Requirement." Enabling Australia - Inquiry into the Migration Treatment of Disability. Joint Standing Committee on Migration". Retrieved from http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=mig/disability/report.htm

---2010. "Chapter 4: Decision Making Processes." Enabling Australia - Inquiry into the Migration Treatment of Disability. Joint Standing Committee on Migration". Retrieved from http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=mig/disability/report.htm

King, Kathleen, Paul. J Douglas, Ken Beath. 2011. "Is premigration health screening for tuberculosis worthwhile?". Retrieved from https://www.mja.com.au/journal/2011/195/9/premigration-health-screening-tuberculosis-worthwhile

NEW ZEALAND

New Zealand, Ministry of Health. 2010. "Guidelines for Tuberculosis Control In New Zealand 2010". Retrieved from http://www.health.govt.nz/system/files/documents/publications/chapter10-guidelines-tuberculosis-control-new-zealand_0.pdf

New Zealand, Immigration

---"Operations Manual: A4 Health Requirements". Retrieved from http://www.immigration.govt.nz/opsmanual/index.htm

---2012. "Amendments to the Immigration New Zealand (INZ) Operational Manual: July Release" Retrieved from http://www.immigration.govt.nz/NR/rdonlyres/C7CC63AA-3B08-4DE1-8FD2-57B1DE1552E0/0/AmendmentCircular201209.pdf

---2012. "Changes to Immigration Health Screening". Retrieved from http://www.immigration.govt.nz/migrant/general/generalinformation/news/healthchanges.htm

---2015. "Health Requirements for Entry to New Zealand". Retrieved from http://www.immigration.govt.nz/NR/rdonlyres/DD2D2D27-DD49-4A62-96CC-3A1F32223C8E/0/INZ1121.pdf

UNITED KINGDOM

UK Visas and Immigration. "Guidance Medical Issues (MED)". Retrieved from https://www.gov.uk/government/publications/medical-issues-med/medical-issues-med#med1-who-requires-a-medical-examination

Public Health England

---2011. "Tuberculosis: The Green Book, Chapter 32". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/148511/Green-Book-Chapter-32-dh_128356.pdf

---2013. "Tuberculosis in the UK 2013 Report". Retrieved from http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139689583

---2013. "TB Surveillance Data". Retrieved from http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/TBUKSurveillanceData/

---2013. "UK Tuberculosis Technical Instructions (UKTBTI): Securing our border, controlling migration". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/245009/UK_tuberculosis_technical_instructions.pdf

Home Office

---"Home Office Policy Equality Statement (PES): Pre-entry tuberculosis screening under immigration powers". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117947/policy-statement-statement.pdf

---"Immigration Rules Part 1". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/286238/Immigration_Rules_-_Part_1.pdf

---"Immigration Rules: Appendix T". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279479/Immigration_Rules_-_Appendix_T.pdf

Home Office, United Kingdom Border Agency

---2012. "Screening for Tuberculosis and the Immigration Control. UK Border Agency Review of Current Screening Activity 2011 (Central Policy Unit)". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117948/tb-screening-review.pdf

---2012. "UK Tuberculosis Technical Instructions (UKTBTI)". Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117946/tb-technical-instructions.pdf

UNITED STATES OF AMERICA

USA, Department of State - Bureau of Consular Affairs, U.S. Visas. "The Immigrant Visa Process". Retrieved from http://travel.state.gov/content/visas/english/immigrate/immigrant-process/interview/prepare/medical-examination.html

United States Government Accountability Office. 2008. "Public Health and Border Security - HHS and DHS Should Further Strengthen Their Ability to Repond to TB Incidents. Report to Congressional Requesters". Retrieved from http://www.gao.gov/new.items/d0958.pdf

--- 2009. "Department of Health and Human Services, Centres for Disease Control and Prevention: Medical Examination of Aliens-Removal of Human Immunodeficiency Virus (HIV) Infection from Definition of Communicable Disease of Public Health Significance". Retrieved from http://www.gao.gov/assets/90/85896.pdf

---2011. "Title 42 - The Public Health and Welfare Chapter 6A - Public Health Service. Subchapter II - General Powers and Duties. Part C - Hospitals, Medical Examinations, and Medical Care. Section 252 - Medical Examinations of Aliens". Retrieved from http://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapII-partC-sec252.htm

--- 2012. "Title 8 - Aliens and Nationality. Chapter 12 - Immigration and Nationality. Subchapter II - Immigration. Part II - Admission Qualifications for Aliens; Travel Control of Citizens and Aliens. Sec. 1182 – Inadmissible aliens". Retrieved from http://www.gpo.gov/fdsys/pkg/USCODE-2012-title8/html/USCODE-2012-title8-chap12-subchapII-partII-sec1182.htm

Centre for Disease Control, USA

Cain, Kevin P. and William R. Mac Kenzie, CDC. 2009. "Overcoming the Limits of Tuberculosis Prevention among Foreign-Born Individuals: Next Steps toward Eliminating Tuberculosis". Clinical Infectious Diseases. 46:107-9

Centres for Law and Public's Health, CDC. 2009. "Tuberculosis Control Laws and Policies: A Handbook for Public Health and Legal Practitioners". Retrieved from http://www.cdc.gov/tb/programs/TBLawPolicyHandbook.pdf

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases. Division of Global Migration and Quarantine. 2009. "CDC Immigration Requirements: Technical Instructions for Tuberculosis Screening and Treatment – Using Cultures and Directly Observed Therapy". Retrieved from http://www.cdc.gov/immigrantrefugeehealth/pdf/tuberculosis-ti-2009.pdf

---2012. "Evaluation of Immigrant Tuberculosis Screening in Industrialized Countries". Retrieved from http://wwwnc.cdc.gov/eid/article/18/9/12-0128-t2.htm

---2012. "Medical Examinations: Frequently Asked Questions (FAQs)". Retrieved from http://www.cdc.gov/immigrantrefugeehealth/exams/medical-examination-faqs.html

---2012. "Fact Sheet: Trends in Tuberculosis, 2012". Retrieved from http://www.cdc.gov/tb/publications/factsheets/statistics/TBTrends.htm

---2012. "Trends in Tuberculosis - United States, 2011". Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6111a2.htm?s_cid=mm6111a2_w

CDC, Division of Global Migration and Quarantine. 2013. "Disease Surveillance Among Newly Arriving Refugees and Immigrants - Electronic Disease Notification System, United States, 2009". Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6207a1.htm

---2013. "Travelers' Health - Chapter 9: Health Considerations for Newly Arrived Immigrants & Refugees". Retrieved from http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-9-health-considerations-for-newly-arrived/introduction

---2013. "Before arrival in the United States: The Overseas Medical Examination." Travelers' Health - Chapter 9: Health Considerations for Newly Arrived Immigrants & Refugees". Retrieved from http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-9-health-considerations-for-newly-arrived/before-arrival-in-the-united-states-the-overseas-medical-examination

---2013. "Arrival in the United States: Health Status & International Adoptees." Travelers' Health - Chapter 9: health Considerations for Newly Arrived Immigrants & Refugees". Retrieved from http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-9-health-considerations-for-newly-arrived/arrival-in-the-united-states-health-status-and-screening-of-refugees-immigrants-and-international-ad

5.0 Stakeholder Surveys

5.1. Visa Office Survey - Instrument

Thank you for taking the time to complete this survey. This survey should be completed only by **CIC Canadian-based Immigration Officers**.

Your responses will be kept confidential, and although these survey responses will be used in a report, the information will be grouped together and no individual responses will be identifiable.

The survey should take you about 20 minutes to complete. Your participation and input are very important. Please do your best to answer all of the questions.

Before you begin:

- *To change the language of the survey, use the link at the top right of the screen.*
- *Unless instructed otherwise, please provide only one answer per question.*
- *On each screen, after selecting your answer(s), click on the "Back" or "Next" buttons at the bottom of the screen to move backwards or forwards in the survey.*
- *If want to save the survey and complete it later, click the 'Save and continue later' button and you will be prompted to enter your e-mail address. You will then receive an e-mail with instructions on how to return to the survey.*
- *Please do not forward this survey to anyone else to complete.*

Section 1 – Profile Information

This information is being collected for analysis purposes only and individual responses will not be shared with anyone outside of the evaluation team or reported in the evaluation report.

1. Please indicate your Visa Office's Regional Medical Office (RMO).

   a. RMO - London
   b. RMO – Manila
   c. RMO – New Delhi
   d. RMO - Ottawa
   e. Do not know

2. Please select the Visa Office in which you currently work.

   Drop-down menu of VOs

3. What is your current position?

   a. Immigration Program Manager
   b. Deputy Program Manager
   c. Unit Supervisor
   d. Senior Immigration Officer
   e. Immigration Officer
   f. Other (please specify) _____

3b. (*If #3=3)* Please indicate the type of files that comprise the majority of your unit's case load.

   a. Economic class (e.g., federal skilled workers, provincial nominees)
   b. Family class (e.g., spouses, dependents, parents, grandparents)
   c. Temporary residents (e.g., students, temporary foreign workers)
   d. Refugees
   e. Other (please specify) _____

4. (*If #3=4-5)* With respect to your current position, please indicate the type of files that comprises the majority of your case load.

   a. Economic class (e.g., federal skilled workers, provincial nominees)
   b. Family class (e.g., spouses, dependents, parents, grandparents)
   c. Temporary residents (e.g., students, temporary foreign workers)
   d. Refugees
   e. Other (please specify) _____

5. How many years in total have you worked within the Foreign Service for CIC (please include any years when you were at CIC headquarters)?

   a. < 1 year

b. 1-5 years
c. 6-10 years
d. 11-15 years
e. 16-20 years
f. 21-25 years
g. > 25 years

Section 2 - Health Screening and Notification Policies

6. Certain applicants who might reasonably be expected to cause *excessive demand* on health or social services (IRPA A38(1)c) may be deemed inadmissible to Canada.

   How easy or difficult do you think it is for CIC officers to assess these types of cases?

   a. Very difficult
   b. DifficultEasy
   c. Very easy
   d. Do not know

7. (*If Q6=1,2*) Can you explain what is difficult about assessing these types of cases?

8. (*If Q6=1,2*) Do you have any suggestions for how these difficulties could be addressed?

9. Applicants found to have active tuberculosis or untreated syphilis are typically assessed as being inadmissible to Canada because they are likely to pose a *danger to public health* (IRPA A38(1)a). If these conditions are treated, an individual can be admissible, but would require surveillance upon arrival in Canada.

   How easy or difficult do you think it is for CIC officers to assess these types of cases?

   a. Very difficult
   b. DifficultEasy
   c. Very easy
   d. Do not know

10. (*If Q9=1,2*) Can you explain what is difficult about assessing these types of cases?

11. (*If Q9*=1) Do you have any suggestions for how these difficulties could be addressed?

12. Applicants are screened for conditions which may pose a *danger to public safety* (IRPA A38(1)b) such as a variety of serious mental health conditions (e.g., sociopathic disorders, pedophilia, violent tendencies).

    How easy or difficult do you think it is for CIC officers to assess these types of cases?

    a. Very difficult
    b. DifficultEasy

c. Very easy
d. Do not know

13. (*If Q12=1,2*) Can you explain what is difficult about assessing these types of cases?

14. (*If Q12=1,2*) Do you have any suggestions for how these difficulties could be addressed?

Section 3 - Tools and Training for Visa Officers

15. To what extent do visa officers have sufficient tools and training (e.g., manuals, operational bulletins, training, workshops) available to them with respect to medical admissibility?

    a. Not at all
    b. To some extent
    c. To a great extent
    d. Cannot comment

16. (*If Q#15=1-3)* Can you please elaborate on any issues with respect to tools and / or training specifically related to medical admissibility?

17. (*If Q#15=13)* Do you have any suggestions for improvements with respect to tools and / or training with respect to medical admissibility?

Section 4 - Communication with the Regional Medical Office

18. How do you communicate with the Regional Medical Office (RMO)? *Please check all that apply.*

    a. Do not communicate with the RMO
    b. Email
    c. Telephone
    d. In-person
    e. Other (please specify)

19. (I*f Q#18 = 2-6*) How would you rate the effectiveness of your communication with the RMO?

    a. Not effective
    b. Somewhat effective
    c. Very effective
    d. Cannot comment

20. (*if Q#19 = 1-3*) Are any improvements required with respect to communications with the RMO (e.g., frequency, mechanisms)?

    a. Yes
    b. No

21. (*If Q#20=1)* Please describe what improvements are needed.

Section 5 - Efficiency of the Medical Screening Process

22. Once a visa office has issued the medical instructions to an applicant, on average, how long does it take to receive the medical assessment?

    Understanding that some cases are complex and may take additional time because of furtherance or treatment, please consider an average case when responding.

    a. < 3 weeks
    b. between 3 and 4 weeks
    c. between 5 and 6 weeks
    d. between 7 and 8 weeks
    e. between 9 and 10 weeks
    f. between 11 and 12 weeks
    g. > 12 weeks (3 months)
    h. Do not know

23. To what extent do you think this timeframe reflects a timely medical screening process?

    a. Not at all
    b. To some extent
    c. To a great extent
    d. Do not know

24. With the implementation of e-medical and the auto clearance feature, please indicate whether there has been any change in the time it takes to obtain the medical assessment?

    U*nderstanding that some cases are complex and may take additional time because of furtherance or treatment, please consider an average case when responding*.

    a. It takes more time to get the medical assessment now that e-medical has been implemented
    b. It takes about the same time to get the medical assessment now that e-medical has been implemented
    c. It takes less time to get the medical assessment now that e-medical has been implemented
    d. Do not know

25. How often do you have to reissue a medical for the same client?

    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Always
    f. Do not know

Other

26. Thank you very much for taking the time to respond to the survey. Do you have any general comments that you would like to make regarding the Health Screening and Notification Program?

5.2. Visa Office Survey - Frequencies

Please indicate your Visa Office's Regional Medical Office (RMO)		
Q1	**n**	**Percent**
RMO - London	41	32.8
RMO - Manila	35	28.0
RMO – New Delhi	15	12.0
RMO - Ottawa	34	27.2
Do not know	0	0.0
Total	**125**	**100.0**

Please select the Visa Office in which you currently work
Q2 – N/A

What is your current position?		
Q3	**n**	**Percent**
Immigration Program Manager	29	23.2
Deputy Program Manager	14	11.2
Unit Supervisor	19	15.2
Senior Immigration Officer	44	35.2
Immigration Officer	19	15.2
Other	0	0.0
Total	**125**	**100.0**

Other (Please specify)
Q3 -- Open ended

Please indicate the type of files that comprise the majority of your unit's case load		
Q3_B	**n**	**Percent**
Economic class (e.g., federal skilled workers, provincial nominees)	6	31.6
Family class (e.g., spouses, dependents, parents, grandparents)	4	21.1
Temporary residents (e.g., students, temporary foreign workers)	6	31.6
Refugees	1	5.3
Other (please specify)	2	10.5
Total	**19**	**100.0**

Other (Please specify)
Q3_B -- Open ended

With respect to your current position, please indicate the type of files that compromises the majority of your case load		
Q4	**n**	**Percent**
Economic class (e.g., federal skilled workers, provincial nominees)	6	9.8
Family class (e.g., spouses, dependents, parents, grandparents)	15	24.6
Temporary residents (e.g., students, temporary	27	44.3

foreign workers)		
Refugees	8	13.1
Other (please specify)	5	8.2
Total	**61**	**100.0**

Other (Please specify)
Q4 -- Open ended

How many years in total have you worked within the Foreign Service for CIC (please include any years when you were at CIC headquarters)?		
Q5	**n**	**Percent**
Less than 1 year	8	6.5
1-5 years	38	30.6
6-10 years	27	21.8
11-15 years	21	16.9
16-20 years	4	3.2
21-25 years	16	12.9
More than 25 years	10	8.1
Total	**124**	**100.0**

Certain applicants who might reasonably be expected to cause excessive demand on health or social services (IRPA A38(1)c) may be deemed inadmissible to Canada. How easy or difficult do you think it is for CIC officers to assess these types of cases?		
Q6	**n**	**Percent**
Very Difficult	13	10.4
Difficult	73	58.4
Easy	27	21.6
Very Easy	4	3.2
Do not know	8	6.4
Total	**125**	**100.0**

Can you explain what is difficult about assessing these types of cases?
Q7 -- Open Ended

Do you have any suggestions for how these difficulties could be addressed?
Q8 -- Open Ended

Applicants found to have active tuberculosis or untreated syphilis are typically assessed as being inadmissible to Canada because they pose a danger to public health (IRPA A38(1)a). If these conditions are treated, an individual can be admissible, but would require surveillance upon arrival in Canada. How easy or difficult do you think it is for CIC officers to assess these types of cases?		
Q9	**n**	**Percent**
Very difficult	1	0.8
Difficult	17	13.6
Easy	81	64.8
Very easy	18	14.4
Do not know	8	6.4
Total	**125**	**100.0**

Can you explain what is difficult about assessing these types of cases?
Q10 - Open ended

Do you have any suggestions for how these difficulties could be addressed?
Q11 - Open ended

Applicants are screened for conditions which may pose a danger to public safety (IRPA A38(1)b) such as a variety of serious mental health conditions (e.g. sociopathic disorders, pedophilia, violent tendencies). How easy or difficult do you think it is for CIC officers to assess these types of cases?		
Q12	**n**	**Percent**
Very difficult	22	17.6
Difficult	40	32.0
Easy	33	26.4
Very easy	4	3.2
Do not know	26	20.8
Total	**125**	**100.0**

Can you explain what is difficult about these types of cases?
Q13 - Open ended

Do you have any suggestions for how these difficulties could be addressed?
Q14 - Open ended

To what extent do visa officers have sufficient tools and training (e.g., manuals, operational bulletins, training, workshops) available to them with respect to medical admissibility?		
Q15	**n**	**Percent**
Not at all	10	8.1
To some extent	67	54.5
To a great extent	37	30.1
Cannot comment	9	7.3
Total	**123**	**100.0**

Can you please elaborate on any issues with respect to tools and/or training specifically related to medical admissibility?
Q16 -- Open ended

Do you have any suggestions for improvements with respect to tools and/or training with respect to medical admissibility?
Q17 -- Open ended

How do you communicate with the Regional Medical Office (RMO)? Please check all that apply.		
Q18	**n**	**Percent**
Do not communicate with RMO	13	8.6
Email	110	72.4
Telephone	15	9.9
In-person	8	5.3
Other	6	3.9
Total	**152**	**100.0**

Other (please specify)
Q18 -- Open ended

How would you rate the effectiveness of your communication with the RMO?		
Q19	**n**	**Percent**
Not effective	2	1.8
Somewhat effective	40	35.4
Very effective	61	54.0
Cannot comment	10	8.8
Total	**113**	**100.0**

Are any improvements required with respect to communications with the RMO (e.g., frequency, mechanisms)?		
Q20	**n**	**Percent**
Yes	24	58.5
No	17	41.5
Total	**41**	**100.0**

Please describe what improvements are needed
Q21 -- Open ended

Once a visa office has issued the medical instructions to an applicant, on average, how long does it take to receive the medical assessment? Understanding that some cases are complex and may take additional time because of furtherance or treatment, please consider an average case when responding.		
Q22	**n**	**Percent**
Less than 3 weeks	26	21.0
Between 3 and 4 weeks	39	31.5
Between 5 and 6 weeks	14	11.3
Between 7 and 8 weeks	13	10.5
Between 9 and 10 weeks	1	0.8
Between 11 and 12 weeks	3	2.4
More than 12 weeks (3 months)	3	2.4
Do not know	25	20.2
Total	**124**	**100.0**

To what extent do you think this timeframe reflects a timely medical screening process?		
Q23	**n**	**Percent**
Not at all	4	4.0
To some extent	34	34.3
To a great extent	55	55.6
Do not know	6	6.1
Total	**99**	**100.0**

With the implementation of e-medical and the auto clearance feature, please indicate whether there has been any change in the time it takes to obtain the medical assessment? Understanding that some cases are complex and may take additional time because of furtherance or treatment, please consider an average case when responding.		
Q24	**n**	**Percent**
It takes more time to get the medical assessment now that e-medical has been implemented	5	4.1
It takes about the same time to get the medical	24	19.7

assessment now that e-medical has been implemented		
It takes less time to get the medical assessment now that e-medical has been implemented	58	47.5
Do not know	35	28.7
Total	**122**	**100.0**

How often do you have to reissue a medical for the same client?		
Q25	**n**	**Percent**
Never	3	2.4
Rarely	33	26.8
Sometimes	58	47.2
Often	21	17.1
Always	0	0.0
Do not know	8	6.5
Total	**123**	**100.0**

Do you have any general comments that you would like to make regarding the Health Screening and Notification Program?
Q26 – Open ended

5.3. Panel Physician Survey - Instrument

Thank you for taking the time to complete this survey. Before you begin:

- To change the language of the survey, please select "French (Canadian)" in the box in the top right-hand corner, then click "Go".
- On each screen, after selecting your answer(s), click on the "Back" or "Next" buttons at the bottom of the screen to move backwards or forwards in the survey.
- If want to save the survey and complete it later, click the 'Save and continue later' button and you will be prompted to enter your e-mail address. You will then receive an e-mail with instructions on how to return to the survey.

Section 1 – Profile Information

Please note that your profile information will not be published and will only be seen by the survey team. The survey team will only report grouped survey responses which will not identify you.

1. Are you currently a Panel Physician that conducts immigration medical examinations (IMES) for Canada?

    a. Yes
    b. No

2. To what Canadian Regional Medical Office (RMO) do you submit your immigration medical exam (IME) results?

    You may have recently been transferred to a new Canadian Regional Medical Office. If so, please answer this question based on your new Regional Medical Office.

    a. RMO – London
    b. RMO - Manila
    c. RMO - New Delhi
    d. RMO – Ottawa
    e. Do not know

3. In what country do you currently practice?

    Drop-down list of countries (If Q#1 = 1-4, list RMO-specific countries; if Q#1 = 5, list all countries)

4. How many years have you been conducting immigration medical examinations (IMEs) **for Canada**?

    Drop-down list with <1, 1-20, >20

5. About how many immigration medical examinations (IMEs) do you conduct **for Canada** each year?

Include only the number of IMEs that you personally conduct each year.

a. Less than 100
b. Between 100-499
c. Between 500-999
d. Between 1,000-1,499
e. Between 1,500-1,999
f. 2,000 or more

6. For what countries are you currently a Panel Physician?

Please check all that apply.

a. Canada
b. Australia
c. New Zealand
d. United Kingdom
e. United States
f. All of these countries

7. What type of medical office do you work in?

a. My own private medical practice
b. In a medical clinic or medical centre
c. In a hospital
d. In a medical facility operated by the International Organization for Migration
e. Other (please specify)

7a. Please indicate your gender.

a. Male
b. Female

Section 2 – Tools for Panel Physicians to Conduct Immigration Medical Examinations

CIC has developed a number of tools for panel physicians to use to conduct Immigration Medical Examinations. These include:

- Panel Members' Handbook
- Medical Forms (e.g., medical report, activities of daily living, referral forms)
- Immigration Medical Examination Instructions (e.g., for hypertension, renal disease)

8. Please indicate how much you disagree or agree with the following statements?

	Strongly disagree	Disagree	Agree	Strongly agree	Do not know
i. The Panel Members' Handbook is easy to use.					
ii. The information provided in the Panel Members' Handbook is easy to understand.					
iii. The information in the Panel Members' Handbook provides me with the information that I need.					
iv. The Medical Forms to conduct the immigration medical examinations are easy to use.					
v. The Immigration Medical Examination Instructions are easy to use.					

9. Do any of these tools need improvement?

	Yes	No
i. Panel Members' Handbook		
ii. Medical Forms		
iii. Immigration Medical Examination Instructions		

10. (*If Q#9i=1*) How does the Panel Members' Handbook need to be improved?

11. (*If Q#9ii=1*) How do the Medical Forms need to be improved?

12. (*If Q#9iii=1*) How do the Immigration Medical Examination Instructions need to be improved?

13. Please indicate how much you disagree or agree with the following statement:

    I have all of the tools I need to do my job as a Panel Physician for CIC?

    a. Strongly disagree
    b. Disagree
    c. Agree
    d. I do not know

14. (*If Q#13 = 1, 2*). What other tools do you need?

Section 3 – Communication with CIC Regional Medical Offices

15. How often do you and your RMO communicate?

    a. Every day
    b. About once a week
    c. A few times a week
    d. About once a month
    e. A few times a month
    f. A few times a year
    g. There is no communication between my RMO and me (*skip to Q#18*)

16. What is the main way you and your RMO communicate?

    a. By e-mail
    b. By telephone
    c. In-person
    d. Fax
    e. Other (please specify)

17. Please indicate how much do you disagree or agree with the following statements?

	Strongly disagree	Disagree	Agree	Strongly agree	Do not know
i. I am satisfied with the method of communication that is used between my RMO and me.					
ii. My RMO and I communicate enough.					
iii. My RMO provides me with information that I need.					
iv. I feel I can contact my RMO any time I have a question or need information.					
v. My RMO responds to my questions quickly.					
vi. I am satisfied with the quality of information I receive from my RMO after making a request.					

18. Does anything need to be improved with respect to communication between you and your RMO?

    a. Yes
    b. No

19. (*If Q#18=1)* Please describe what improvements are needed.

Section 4 – E-Medical

20. Are you currently using e-medical to provide IME results to Canada?

    a. Yes
    b. No (skip to Section 5)

21. (*If Q#20=1*) When did you first start using the e-medical system to provide IME results to Canada?

    Insert calendar with month, year

22. For the majority of IMEs that you conduct, please pick the most accurate statement:

    a. I record the medical results on paper, then I enter them in e-medical later.
    b. I record the medical results on paper, then another staff member enters them in e-medical.
    c. I enter the medical results directly in e-medical while the IME is being conducted.
    d. Other (please specify)

23. Please indicate what type of training you received on e-medical.

    Check all that apply.

    a. I did not receive any training on e-medical
    b. I went to an e-medical training session in Paris, France
    c. Someone in my office or region went to the training in Paris, France and then provided me with training
    d. Someone came to my office and provided me with training
    e. I participated in a teleconference that provided information on e-medical
    f. I participated in a webinar on e-medical
    g. I used an e-medical training CD
    h. Other (please specify)

24. (*If Q#23=1-7)* With respect to the e-medical training that you received, please indicate how much you disagree or agree with the following statements?

	Strongly disagree	Disagree	Agree	Strongly agree	Do not know
The training I received on e-medical was good quality.					
The information provided during the e-medical training was useful.					
I received enough training on e-medical.					

25. With respect to the e-medical system, please indicate how much you disagree or agree with the following statements?

	Strongly disagree	Disagree	Agree	Strongly agree	Do not know
E-medical was easy to implement in my office.					
The e-medical system is easy to use.					
The speed of the system is good.					
Most of the time the system is working (i.e., it is not out of service)					
Good technical support is available when there are problems.					
Overall, e-medical is a good system for my office.					

26. Has e-medical changed the time it takes you to conduct an IME?

    This includes the time it takes to conduct the IME <u>and</u> submit the medical results to Canada.

    a. It takes more time to conduct an IME with e-medical.
    b. It takes about the same time to conduct an IME with e-medical.
    c. It takes less time to conduct an IME with e-medical.
    d. Do not know

27. Do you have any comments you would like to make regarding e-medical?

Section 5 - Other

28. Do you think that Canada's immigration medical examination procedures allow you to identify individuals with the following conditions?

	No, not at all	Somewhat	Yes, very much	Do not know
Active tuberculosis				
Inactive tuberculosis				
Latent tuberculosis				
Syphilis				
Mental health conditions that would be violent or harmful to others				
Other chronic conditions or diseases (e.g., diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)				

Do you have any comments on this question?

29. When a client has one of the following conditions, does your office contact them to let them know?

	Yes	No
Active tuberculosis		
Inactive tuberculosis		
Latent tuberculosis		
Syphilis		
Mental health conditions that would be violent or harmful to others		
Other chronic conditions or diseases (e.g., diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)		

Do you have any comments on this question?

30. When a client has one of the following conditions, does your office give them any information to help them understand their condition?

	Yes	No
Active tuberculosis		
Inactive tuberculosis		
Latent tuberculosis		
Syphilis		
Mental health conditions that would be violent or harmful to others		
Other chronic conditions or diseases (e.g., diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)		

Do you have any comments on this question?

31. Do you give clients a copy of their medical exam results?

    a. Yes, I give all clients a copy of their medical exam results.
    b. I give clients a copy of their medical exam results if they have a serious medical condition (i.e., tuberculosis, HIV).
    c. I only give clients a copy of their medical exam results if they request them.
    d. No, I never give clients a copy of their medical exam results.
    e. Other (please specify)

32. (*If Q#1=2*) This survey is for Panel Physicians that currently conduct Immigration Medical Examinations for Canada. Thank you for your interest, however, you do not need to complete this survey. If you have any general comments about CIC's Health Screening and Notification Program, you can use the space below.

    Click the 'next' button to end the survey.

    End Survey

33. Thank you very much for taking the time to respond to the survey. Do you have any general comments that you would like to make regarding CIC's Health Screening and Notification Program?

    Click the 'Submit' button to complete the survey.

    End Survey

5.4. Panel Physician Survey - Frequencies

To what Canadian Regional Medical Office do you submit your immigration medical exam (IME) results?		
Q2	**n**	**Percent**
RMO - London	192	36.9
RMO - New Delhi	64	12.3
RMO - Ottawa	151	29.0
RMO – Manila	114	21.9
Total	**521**	**100.0**

In what country do you currently practice?
Q3 – Open Ended

How many years have you been conducting immigration medical examinations (IMEs) for Canada?		
Q4	**n**	**Percent**
Less than 1 year	25	4.9
1 to 5 years	180	35.2
6 to 10 years	98	19.2
11 to 15 years	65	12.7
16 to 20 years	59	11.5
More than 20 years	84	16.4
Total	**511**	**100.0**

About how many immigration medical examinations (IMEs) do you conduct for Canada each year? (include only the number of IMEs)
Q5 – Open ended

For what countries are you currently a Panel Physician?
Q6 – Open ended

What type of medical office do you work in?		
Q7	**n**	**Percent**
In my own medical practice	190	36.5
In a medical clinic or medical centre	176	33.8
In a hospital	90	17.3
In a medical facility operated by the International Organization for Migration	58	11.1
Other (please specify)	7	1.3
Total	**521**	**100.0**

Please indicate your gender		
Q7_A	**n**	**Percent**
Not indicated	1	0.2
Female	194	37.2
Male	326	62.6
Total	**521**	**100.0**

Please indicate how much you disagree or agree with the following statements						
Q8	n	Percent				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Do not know
Handbook is easy to use	517	31.7	63.1	4.4	0.8	0.8
The information provided in the Panel Members' Handbook is easy to understand	516	35.9	61.2	2.9	0.0	0.6
The information in the Panel Members' Handbook provides me with the information that I need	516	30.0	67.1	2.5	0.4	0.4
The Medical Forms to conduct the immigration medical examinations are easy to use	517	40.0	56.7	3.3	0.0	0.4
The Immigration Medical Examination Instructions are easy to use	518	36.7	58.9	3.9	0.6	0.6

Do any of these tools need improvement?			
Q9	n	Percent	
		Yes	No
Panel Members' Handbook	515	19.8	80.2
Medical Forms	513	17.9	82.1
Immigration Medical Examination Instructions	511	15.3	84.7

How does the Panel Members' handbook need to be improved?
Q10 – Open ended

How does the Medical Forms need to be improved?
Q11 – Open ended

How does the Immigration Medical Examination Instructions need to be improved?
Q12 – Open ended

Indicate how much you disagree or agree with the following statement						
Q13	n	Percent				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I have all the tools I need to do my job as a Panel Physician for CIC	519	33.2	60.5	3.3	1.3	1.3

What other tools do you need?
Q14 – Open Ended

How often do you and your RMO communicate		
Q15	n	Percent
Every day	2	0.4
About once a week	25	4.8
A few times a week	24	4.6
About once a month	104	20.1
A few times a month	82	15.8
A few times a year	250	48.3
There is no communication between my RMO	31	6.0

and me		
Total	**518**	**100.0**

What is the main way you and your RMO communicate		
Q16	**n**	**Percent**
By e-mail	469	95.9
By telephone	13	2.7
In-Person	2	0.4
Fax	1	0.2
Other (Please Specify)	4	0.8
Total	**489**	**100.0**

Indicate how much you disagree or agree with the following statements						
		Percent				
Q17	**n**	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**
I am satisfied with the method of communication that is used between my RMO and me	489	33.3	58.9	5.9	1.2	0.6
My RMO and I communicate enough	489	23.9	62.8	9.8	1.2	2.2
My RMO provides me with information that I need	489	33.3	58.9	5.9	1.2	0.6
I am satisfied with the quality of information I receive from my RMO after making a request	488	36.6	56.0	4.7	0.8	1.8

Indicate how much you agree or disagree with the following statements					
	Percent				
Q17_I am satisfied with the method of communication that is used between my RMO and me	**RMO – Manila (n=107)**	**RMO – London (n=177)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=144)**	**Total (n=489)**
Strongly agree	23.4	37.9	37.7	33.3	33.3
Agree	72.0	55.4	60.7	52.8	58.9
Disagree	3.7	5.1	1.6	10.4	5.9
Strongly disagree	0.0	1.7	0.0	2.1	1.2
Do not know	0.9	0.0	0.0	1.4	0.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Indicate how much you agree or disagree with the following statements					
	Percent				
Q17_My RMO and I communicate enough	**RMO – Manila (n=106)**	**RMO – London (n=178)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=144)**	**Total (n=489)**
Strongly agree	15.1	27.5	27.9	24.3	23.9
Agree	71.7	60.1	65.6	58.3	62.8
Disagree	10.4	8.4	6.6	12.5	9.8
Strongly disagree	0.0	2.2	0.0	1.4	1.2
Do not know	2.8	1.7	0.0	3.5	2.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Indicate how much you agree or disagree with the following statements					
	Percent				
Q17_My RMO provides me with the information that I need	**RMO – Manila (n=107)**	**RMO – London (n=178)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=143)**	**Total (n=489)**
Strongly agree	26.2	36.5	36.1	34.3	33.5
Agree	69.2	58.4	62.3	58.7	61.3
Disagree	2.8	2.8	0.0	3.5	2.7
Strongly disagree	0.0	1.7	1.6	2.1	1.4
Do not know	1.9	0.6	0.0	1.4	1.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Indicate how much you agree or disagree with the following statements					
	Percent				
Q17_I feel I can contact my RMO anytime I have questions	**RMO – Manila (n=106)**	**RMO – London (n=178)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=143)**	**Total (n=488)**
Strongly agree	30.2	42.1	37.7	35.7	37.1
Agree	59.4	51.1	57.4	49.0	53.1
Disagree	7.5	4.5	3.3	9.1	6.4
Strongly disagree	0.9	1.1	0.0	4.9	2.0
Do not know	1.9	1.1	1.6	1.4	1.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Indicate how much you agree or disagree with the following statements					
	Percent				
Q17_My RMO responds to my questions quickly	**RMO – Manila (n=107)**	**RMO – London (n=175)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=143)**	**Total (n=486)**
Strongly agree	29.9	39.4	29.5	34.3	34.6
Agree	59.8	51.4	67.2	51.0	55.1
Disagree	6.5	6.3	1.6	10.5	7.0
Strongly disagree	0.0	1.1	1.6	2.8	1.4
Do not know	3.7	1.7	0.0	1.4	1.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Indicate how much you agree or disagree with the following statements					
Q17_I am satisfied with the quality of information I receive after making a request	**Percent**				
	RMO – Manila (n=106)	**RMO – London (n=178)**	**RMO - New Delhi (n=61)**	**RMO – Ottawa (n=144)**	**Total (n=489)**
Strongly agree	28.3	42.1	32.8	37.5	36.6
Agree	64.2	51.7	65.6	51.4	56.0
Disagree	2.8	3.4	1.6	9.0	4.7
Strongly disagree	0.0	1.1	0.0	1.4	0.8
Do not know	4.7	1.7	0.0	0.7	1.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Does anything need to be improved with respect to communication between you and your RMO?		
Q18	**n**	**Percent**
Yes	120	23.1
No	400	76.9
Total	**520**	**100.0**

Please describe what improvements are needed
Q19 - Open

Are you currently using e-medical to provide IME results to Canada?		
Q20	**n**	**Percent**
Yes	447	85.8
No	74	14.2
Total	**521**	**100**

Are you currently using e-medical to provide IME results to Canada?			
Q20_By RMO	**n**	**Percent**	
		Yes	**No**
RMO – Manila	114	95.6	4.4
RMO – London	192	77.6	22.4
RMO - New Delhi	64	82.8	17.2
RMO – Ottawa	151	90.1	9.9
Total	**521**	**85.8**	**14.2**

When did you first start using the e-medical system to provide IME results to Canada?
Q21 – Open Ended

For the majority of IMEs that you conduct, please pick the most accurate statement					
Q22_ByRMO	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=149)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=447)**
I enter the medical results directly in e-medical while the IME is being conducted.	30.3	58.4	32.1	44.1	44.1
I record the medical results on paper, then I enter them in e-medical later.	59.6	34.2	58.5	40.4	45.2
I record the medical results on paper, then another staff enters them in e-medical.	6.4	4.0	7.5	12.5	7.6
Combination of on paper and on-line	1.8	3.4	1.9	2.9	2.7
Other (please specify)	1.8	0.0	0.0	0.0	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

For the majority of IMEs that you conduct, please pick the most accurate statement					
Q23_ByRMO	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=149)**	**RMO - New Delhi (n=64)**	**RMO – Ottawa (n=136)**	**Total (n=447)**
Someone came to my office and provided me with training	47.7	31.5	54.7	21.3	36.5
I used an e-medical training CD	21.1	36.9	15.6	37.5	31.1
I participated in a webinar on e-medical	22.9	20.1	20.3	47.1	29.5
I participated in a teleconference that provided information on e-medical	25.7	22.8	4.7	44.9	28.2
Someone in my office or region went to the training in Paris, France and then provided me with training	4.6	10.7	14.1	0.0	6.7
Did not receive any training	4.6	6.7	6.3	2.2	4.9
Was already trained on e-health	5.5	4.0	3.1	0.7	3.4
On-the job, from other PPs, colleagues, admin staff	3.7	4.7	1.6	0.7	2.9
Attended a conference, training session	3.7	2.0	3.1	2.9	2.9
Other	0.9	4.0	6.3	0.0	2.5
Went to training in Paris, France	0.9	3.4	0.0	0.0	1.3

**Will add to more than 100% as the respondents could choose all that apply.*

With respect to the e-medical training that you received, please indicate how much you disagree or agree with the following statements						
Q24	**n**	**Percent**				
		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Do not know**
The training I received on e-medical was good quality	422	24.4	62.6	10.0	2.1	0.9
The information provided during the e-medical training was useful	422	26.3	67.3	5.0	0.7	0.7
I received enough training on e-medical	422	19.7	59.5	16.1	3.1	1.7

With respect to the e-medical training that you received, please indicate how much you disagree or agree with the following statements					
Q24_The training I received was good quality	**Percent**				
	RMO – Manila (n=102)	**RMO – London (n=137)**	**RMO - New Delhi (n=50)**	**RMO – Ottawa (n=133)**	**Total (n=422)**
Strongly disagree	0.0	0.7	0.0	6.0	2.1
Disagree	5.9	10.9	4.0	14.3	10.0
Agree	65.7	67.9	58.0	56.4	62.6
Strongly agree	27.5	19.0	38.0	22.6	24.4
Do not know	1.0	1.5	0.0	0.8	0.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical training that you received, please indicate how much you disagree or agree with the following statements					
Q24_Information provided was useful	**Percent**				
	RMO – Manila (n=102)	**RMO – London (n=137)**	**RMO - New Delhi (n=50)**	**RMO – Ottawa (n=133)**	**Total (n=422)**
Strongly disagree	0.0	0.7	0.0	1.5	0.7
Disagree	3.9	2.2	2.0	9.8	5.0
Agree	67.6	70.1	68.0	63.9	67.3
Strongly agree	27.5	25.5	30.0	24.8	26.3
Do not know	1.0	1.5	0.0	0.0	0.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical training that you received, please indicate how much you disagree or agree with the following statements					
Q24_I received enough training on e-medical	**Percent**				
	RMO – Manila (n=102)	**RMO – London (n=137)**	**RMO - New Delhi (n=50)**	**RMO – Ottawa (n=133)**	**Total (n=422)**
Strongly disagree	0.0	2.2	0.0	7.5	3.1
Disagree	8.8	15.3	12.0	24.1	16.1
Agree	65.7	62.8	62.0	50.4	59.5
Strongly agree	24.5	16.1	26.0	17.3	19.7
Do not know	1.0	3.6	0.0	0.8	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.						
Q25	**n**	**Percent**				
		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Do not know**
E-medical was easy to implement in my office.	445	22.2	61.1	0.4	13.3	2.9
The e-medical system is easy to use.	446	29.1	62.6	0.2	7	1.1
The speed of the system is good.	446	11.2	43.3	0.4	35.4	9.6
Most of the time the system is working (i.e., it is not out of service)	447	22.4	70	0	7.2	0.4
Good technical support is available when there are problems.	447	18.8	59.7	3.8	13	4.7
Overall, e-medical is a good system for my office.	445	31.7	62.9	0.7	3.4	1.3

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.					
Q25_E-medical was easy to implement in my office	**Percent**				
	RMO – Manila (n=108)	**RMO – London (n=148)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=445)**
Strongly disagree	0.0	2.7	0.0	6.6	2.9
Disagree	5.6	11.5	3.8	25.0	13.3
Agree	71.3	58.8	66.0	53.7	61.1
Strongly agree	22.2	26.4	30.2	14.7	22.2
Do not know	0.9	0.7	0.0	0.0	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.					
Q25_The e-medical system is easy to use	**Percent**				
	RMO – Manila (n=108)	**RMO – London (n=149)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=446)**
Strongly disagree	1.9	0.7	0.0	1.5	1.1

Disagree	4.6	6.0	1.9	11.8	7.0
Agree	66.7	63.1	58.5	60.3	62.6
Strongly agree	26.9	29.5	39.6	26.5	29.1
Do not know	0.0	0.7	0.0	0.0	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.

Q25_The speed of the system is good	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=148)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=446)**
Strongly disagree	6.4	7.4	9.4	14.7	9.6
Disagree	25.7	41.2	32.1	38.2	35.4
Agree	60.6	36.5	52.8	33.1	43.3
Strongly agree	6.4	14.2	5.7	14.0	11.2
Do not know	0.9	0.7	0.0	0.0	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.

Q25_Most of the time the system is working (i.e., it is not out of service)	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=149)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=447)**
Strongly disagree	0.0	1.3	0.0	0.0	0.4
Disagree	8.3	10.1	5.7	3.7	7.2
Agree	77.1	63.1	73.6	70.6	70.0
Strongly agree	14.7	25.5	20.8	25.7	22.4
Do not know	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.

Q25_Good technical support is available when there are problems	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=149)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=447)**
Strongly disagree	1.8	2.7	3.8	9.6	4.7
Disagree	9.2	8.1	3.8	25.0	13.0
Agree	70.6	63.1	73.6	41.9	59.7
Strongly agree	16.5	21.5	17.0	18.4	18.8
Do not know	1.8	4.7	1.9	5.1	3.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

With respect to the e-medical system, please indicate how much you disagree or agree with the following statements.					
Q25_Overall, e-medical is a good system for my office.	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=147)**	**RMO - New Delhi (n=53)**	**RMO – Ottawa (n=136)**	**Total (n=445)**
Strongly disagree	1.8	1.4	0.0	1.5	1.3
Disagree	1.8	4.1	1.9	4.4	3.4
Agree	70.6	61.2	60.4	59.6	62.9
Strongly agree	25.7	32.0	37.7	33.8	31.7
Do not know	0.0	1.4	0.0	0.7	0.7
Total	100.0	100.0	100.0	100.0	100.0

Has e-medical changed the time it takes you to conduct an IME? This includes the time it takes to conduct the IME and submit the medical results to Canada.		
Q26	**n**	**Percent**
It takes more time to conduct an IME with e-medical	174	39.1
It takes about the same time to conduct an IME with e-medical	119	26.7
It takes less time to conduct an IME with e-medical	136	30.6
Do not know	16	3.6
Total	**445**	**100.0**

Has e-medical changed the time it takes you to conduct an IME? This includes the time it takes to conduct the IME and submit the medical results to Canada.					
Q26_ByRMO	**Percent**				
	RMO – Manila (n=109)	**RMO – London (n=149)**	**RMO - New Delhi (n=51)**	**RMO – Ottawa (n=136)**	**Total (n=445)**
It takes about the same time to conduct an IME with e-medical.	24.8	25.5	27.5	29.4	26.7
It takes less time to conduct an IME with e-medical.	38.5	26.8	31.4	27.9	30.6
It takes more time to conduct an IME with e-medical.	27.5	44.3	41.2	41.9	39.1
Do not know	9.2	3.4	0.0	0.7	3.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Do you have any comments you would like to make regarding e-medical?
Q27 – Open Ended

Do you think that Canada's immigration medical examination procedures allow you to identify individuals with the following conditions?					
Q28	**n**	**Percent**			
		No, not at all	**Somewhat**	**Yes, very much**	**Do not know**
Active tuberculosis	521	1.7	7.5	90	0.8
Inactive Tuberculosis	520	2.1	21.9	74.4	1.5
Latent Tuberculosis	519	11	34.9	50.9	3.3
Syphilis	520	1.7	7.1	90	1.2
Mental health conditions that would be violent or harmful to others	517	7.9	37.5	52.2	2.3
Other chronic conditions or diseases (e.g., diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)	519	2.7	31.8	64.4	1.2

Do you have any comments on this question?
Q28_A – Open Ended

When a client has one of the following conditions, does your office contact them to let them know?			
Q29	**n**	**Percent**	
		Yes	**No**
Active Tuberculosis	517	98.6	1.3
Inactive Tuberculosis	517	87.0	12.9
Latent Tuberculosis	512	87.9	12.1
Syphilis	517	97.5	2.5
Mental Health conditions that would be violent or harmful to others	513	91.8	8.18
Other chronic conditions or diseases (e.g. diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)	518	95.4	4.6

Do you have any comments on this question?
Q29_A -- Open

When a client has one of the following conditions, does your office give them any information to help them understand their condition?			
Q30	**n**	**Yes**	**No**
Active Tuberculosis	516	493	23
Inactive Tuberculosis	515	495	56
Latent Tuberculosis	513	449	64
Syphilis	516	491	25
Mental health Conditions that would be violent or harmful to others	514	457	57
Other chronic conditions or diseases (e.g. diabetes, hypertension, chronic renal disease, hepatic disease, hepatitis)	515	478	37

Do you have any comments on this question?
Q30_A -- Open

Do you give clients a copy of their medical exam results?		
Q31	**n**	**Percent**
Yes, I give all clients a copy of their medical exam results.	21	4
I only give clients a copy of their medical exam results if they have a serious medical condition (i.e., tuberculosis, HIV).	175	33.6
I only give clients a copy of their medical exam results if they request them.	298	57.2
No, I never give clients a copy of their medical exam results.	97	18.6
I only give them the lab and/or x-ray results if they ask or if necessary	30	5.8
Other	14	2.7
Total	**521**	**100.0**

Other (please specify)
Q31_D -- Open

If you have any general comments about CIC's health screening and notification program, you can use the space below
Q32 -- Open

5.5. Public Health Unit Survey - Instrument

INTRODUCTION

CALL #1 – Arranging a suitable time

[R1]
Hello Mr/Ms _____, I am calling from R.A. Malatest & Associates Ltd., an independent research organization. We have been hired by the Department of Citizenship and Immigration Canada, otherwise known as (CIC), to administer a survey of Public Health Units across Canada about CIC's medical surveillance and notification process. You were recently sent an email from CIC about this survey.

In the past five years, has your office seen any recent migrants for TB-related issues, whether referred by CIC or NOT?

a. Yes
b. No

[If no] The objective of this survey is to obtain feedback from health units that have seen recent migrants for TB-related issues and about the CIC medical surveillance notification process. Since your office does not see any of these cases, the survey does not apply to you. Thank you very much for your time.

[If yes] I'm calling you today to set up a convenient time for you to take the survey, which should take about 20 minutes. Would we be able to set up a time now?

[If respondent provides best time, record the interview time and thank them]
[If respondent requests more information about the survey/evaluation, refer to 'Survey Backgrounder' in Annex A for an appropriate response]
[If respondent states they are not the best person to conduct the survey, record the name, title, contact information, and rationale for the recommended alternative]
[If respondent indicates they do not wish to do the survey, refer to [R2]]

[R2]
I'm sorry to hear that. Your participation is voluntary, however understanding your views is important as they would inform future policy decisions which may have an impact on the improvement of medical screening, notification, and surveillance procedures that help to ensure the safety, security and health of Canadians. All personal information collected during the survey would be kept confidential. We realize that people are very busy, and we would be happy to complete the survey with you at a time that is most convenient for you.
[Depending on the response: end survey (disagree) or reschedule (if new time is suggested) – record information in database]

CALL #2 - Conducting the Survey
Hello Mr/Ms _____, this is _____, from R.A. Malatest & Associates Ltd. We spoke a few days/weeks ago about a setting up a time for you to conduct a survey on CIC's Health Screening and Notification Program? Is now still a good time?

[If respondent requests more information about the survey/evaluation, refer to 'Survey Backgrounder' in Annex A for an appropriate response]
[If respondent provides another more convenient time, record the interview time and thank them]
[If respondent wishes to continue, read [R3] and conduct the survey]

[R3]
Thank you for agreeing to participate! Just as a reminder, all personal information and feedback collected during the survey will be kept confidential and the information that you provide will never be connected to you, personally in any reports. If you're ready, we can begin.

SURVEY

Profile Questions
I'd like to start by asking you a few profile questions. Just as a reminder, your profile information will not be published and will only be seen by the survey team.
1. What is your current position at the __[*Location of PHU*]__ office? _____

2. How long have you been in your current position? _____ [*years*]

Program Design and Management Questions

I will now ask you a few questions related to the information that you have available to you on CIC's medical notification program.

3. Using a scale of 1 to 5 where 1 is 'strongly disagree', and 5 is 'strongly agree,' please indicate your level of agreement with the following statements.

   a. I have enough information on CIC's medical notification program.

Strongly Disagree				Strongly agree	Do not know
1	2	3	4	5	9

   b. I know who to contact within CIC if I have questions regarding the notification program.

Strongly Disagree				Strongly agree	Do not know
1	2	3	4	5	9

4. (*If Q3a=1-3*)What additional information or support is needed from CIC?

5. To what extent does the medical information provided with the surveillance notification meet your needs?

Not at all		Somewhat		To a great extent	Do not know
a.	b.	c.	d.	e.	f.

6. For what proportion of cases does your office request additional medical information for individuals referred to you by CIC for surveillance? *Note: here we are referring to the medical information that would have been gathered from the client during the Immigration Medical Examination*.

   a. None
   b. In less than 25% of cases
   c. Between 25-50% of cases
   d. Between 51-75% of cases
   e. Between 76-99% of cases
   f. In 100% of cases (skip to Q#8)

7. Can you explain why in certain cases you do not request additional medical information? (Probe: is the information provided with the notification sufficient, or are there other reasons?)

8. *(if Q6 does not equal a)*To whom do you make the request for additional medical information?

   a. CIC
   b. The Ministry of Health in my Province or Territory
   c. Other (*please specify*)

9. *(if Q6 does not equal a)*On average, how long does it take to receive the additional medical information that was requested?

   a. < 1 week
   b. Between 1 to 2 weeks
   c. Between 2 to 4 weeks
   d. Between 1-2 months
   e. > 2 months

10. *(if Q6 does not equal a)*Using a scale from 1 to 5 where 1 is 'not at all', 3 is 'somewhat' and 5 is 'to a great extent,' to what extent do you feel that the additional medical information you request is received by your office in a timely manner?

Not at all		Somewhat		To a great extent	Do not know
a.	b.	c.	d. *(skip to Q#12)*	e. *(skip to Q#12)*	f.

11. *(if Q6 does not equal a)*When the additional requested information is not received in a timely manner, how does this affect your office and/or the surveillance process?

12. *(if Q6 does not equal a)*What additional medical information is typically requested? (*check all that apply*)

    a. Chest X-ray
    b. Laboratory test results (e.g., blood, urine)
    c. Treatment history
    d. Medical report
    e. Other (*please specify*): _____

13. *(if Q6 does not equal a)*Using a scale from 1 to 5 where 1 is 'not at all', 3 is 'somewhat' and 5 is 'to a great extent,' to what extent is the additional medical information that is provided, the information you need?

Not at all		Somewhat		To a great extent	Do not know
a.	b.	c.	d.	e. *(skip to Q#15)*	f. *(skip to Q#15)*

14. *(if Q6 does not equal a)*What are the gaps in the medical information you receive from CIC?

PHU Clients (recent migrants who are being seen for TB-related issues)

*The next few questions relate to recent migrants that you see in your office for TB-related issues. By 'recent migrants', we mean those individuals who have arrived in Canada in the past 5 years. By 'TB-related issues', we mean individuals who are being seen by your office because CIC requires them to undergo surveillance **OR** because they are undergoing examination or treatment because they have been identified as having active or inactive TB since arriving in Canada.*

15. In an average year, can you estimate the number of recent migrants that you see in your office for TB-related issues whether referred by CIC or NOT?

a. < 5
b. Between 5-9
c. Between 9-24
d. Between 25-49
e. Between 75-99
f. Between 100-149
g. Between 150-199
h. Between 200-249
i. 250 or more
j. Do not know

16. Out of these cases, can you estimate what proportion would have been referred to you through a CIC medical surveillance notification?

a. None: 0%
b. 1-19%
c. 20% -39%
d. 40% -59%
e. 60%-79%
f. 80%-99%
g. All: 100% (*skip to Q#19)*
h. Do not know *(skip to Q#23)*

17. Thinking of the recent migrants that you see for TB-related issues that were **not** referred to you by CIC, are you able to indicate what type of migrant comprises the majority of these cases?

a. Visitors (those in Canada for less than 6 months)
b. Students
c. Temporary foreign workers
d. Recently landed permanent residents
e. Refugees/refugee claimants
f. Other (please specify): _____
g. Do not know

18. When your office sees a recent migrant for TB-related issues who was **not** referred by CIC, to your knowledge, is CIC eventually notified of these types of cases?

a. Yes
b. No
c. Do not know

19. *(if not Q16=a)* Thinking of the recent migrants that you see for surveillance that **were referred by CIC**, can you indicate your office's normal process for establishing contact with the surveillance client? (read list)

a. My office contacts the surveillance client when we receive the notification from CIC or my Province / Territory.
b. My office relies on the surveillance client to contact us.
c. Combination of both processes.

20. *(if not Q64=a)* Usually, is contact between your PHU and the client easily established?

a. Yes
b. No

21. *(if not Q16=a)* What are the challenges in establishing contact with surveillance clients that CIC has notified you of? (select all that apply)

a. Incorrect client contact information on file
b. Insufficient client contact information on file (e.g. lack of phone, email, etc.)
c. Client not provided with correct PHU contact information
d. Transience / mobility of some recent migrants
e. Recent migrants are not available during PHU office hours
f. Recent migrants do not return calls/emails from PHU
g. CIC surveillance notifications are not received in a timely manner following the client's entry into Canada
h. There are no challenges
i. Other

22. *(if not Q16=a)* How frequently does your office receive a surveillance notification from CIC for an individual <u>after</u> that individual has already made contact with your office?

a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Do not know

23. Once a recent migrant that has been referred to you for surveillance has complied with his/her surveillance requirement, who do you notify about this compliance?

a. CIC
b. My Provincial / Territorial health authority
c. I do not report on compliance *(skip to Q#26)*
d. Do not know *(skip to Q#26)*

24. At what point in the surveillance process does your office send the notification to CIC or the provincial/territorial health authority that an individual has complied with their surveillance requirements?

    a. Once my office has established initial contact with the surveillance client.
    b. Once the surveillance client has completed the first medical assessment at a health clinic for their condition.
    c. Once the surveillance client has completed all follow-up assessments and treatments.
    d. Do not know

25. To what extent do your surveillance clients comply with their **CIC** surveillance requirements?

Not at all		Somewhat		To a great extent	Do not know
a.	b.	c.	d.	e.	f.

26. At what point in the surveillance process does **your office** consider that an individual has fully satisfied his/her medical requirements to the Province/Territory?

    a. Once my office has established initial contact with the surveillance client.
    b. Once the surveillance client has completed the first medical assessment at a health clinic for their condition.
    c. Once the surveillance client has completed all follow-up assessments and treatments.
    d. Do not know

27. On a scale from 1 to 5 where 1 is 'not at all,' 3 is 'somewhat,' and 5 is 'to a great extent,' to what extent do you agree with the following statements about the level of understanding surveillance clients have about their medical conditions and surveillance responsibilities.

    a. Prior to connecting with a Provincial / Territorial health authority, the information that surveillance clients receive about their condition is sufficient.
    b. Prior to connecting with a Provincial / Territorial health authority, the information that surveillance clients receive about their condition is clear.
    c. Surveillance clients that are referred to my office have a sufficient level of understanding about their medical condition.
    d. Surveillance clients that are referred to my office have a sufficient level of understanding about their surveillance responsibilities.

<u>Questions Related to CIC's Health Screening and Notification Program</u>

I will now ask you a few questions about your views concerning CIC's medical screening procedures and how well you feel these procedures are at identifying migrants who have tuberculosis.

28. As you may already know, Canada currently prevents the entry of individuals applying to come to Canada who have been identified through medical screening as having **<u>active</u>** tuberculosis. Do you

feel that CIC should continue to prevent the entry of individuals applying to come to Canada that are found to have **active** tuberculosis?

a. Yes
b. No

29. Could you please provide a reason for your response? [*Open ended response*]

30. CIC currently allows the entry of individuals applying to come to Canada who have been identified as having **inactive** tuberculosis, but requires these individuals to undergo medical surveillance once they are in the country. Do you feel that CIC should **continue to require medical surveillance in Canada** for migrants identified as having **inactive** tuberculosis?

a. Yes
b. No

31. Can you tell me why you feel this way? [*Open ended response*]

32. As you may already be aware, certain individuals who wish to enter Canada are not required to undergo medical screening, such as visitors who are staying in Canada for less than six months. Based on the individuals that you see in your office, do you feel that the right types of applicants are being required by CIC to undergo medical screening?

a. Yes
b. No
c. Don't know

33. Can you tell me why you feel this way? [*Open ended response*]

34. Currently, the primary method that CIC uses to screen applicants for TB is a chest X-Ray. However, in some cases, additional testing using a skin test or IGRA test may be administered if a CIC medical officer determines that a chest X-Ray is inconclusive or if further testing is warranted due to additional risk factors. Using a scale from 1 to 5 where 1 is 'not at all', 3 is 'somewhat' and 5 is 'to a great extent,' to what extent do you feel this screening approach is capable of detecting tuberculosis infection in applicants wishing to come to Canada?

Not at all		Somewhat		To a great extent	Do not know
a.	b.	c.	d. *(skip to Q#36)*	e. *(skip to Q#36)*	f.

35. How could CIC better detect TB?
[*Open ended response*]

36. This takes us through all of the questions I had today. Is there anything you would like to add or clarify with respect to CIC's medical notification program?
[*Open ended response*]

Thank you for taking the time to respond to this survey.

5.6. Public Health Unit Survey - Frequencies

What is your current position at the [Location of PHU] office?
Q1 – Open ended

How long have you been in your current position?
Q2 – Open ended

I have enough information on CIC's medical notification program.		
Q3_A	**Frequency**	**Percent**
1- Strongly Disagree	0	0
2	8	14.5
3	24	43.6
4	16	29.1
5 - Strongly Agree	6	10.9
Do not know	1	1.8
Total	**55**	**100.0**

I know who to contact within CIC if I have questions regarding the notification program		
Q3_B	**Frequency**	**Percent**
1 - strongly disagree	7	12.7
2	8	14.5
3	13	23.6
4	10	18.2
5 - strongly agree	17	30.9
Total	**55**	**100.0**

What additional information or support is needed from CIC?
Q4 – Open Ended

To what extent does the medical information provided with the notification meet your needs?		
Q5	**Frequency**	**Percent**
1 - not at all	1	1.8
2	7	12.7
3 - somewhat	20	36.4
4	16	29.1
5 - to a great extent	6	10.9
Field test respondents - not asked this question	4	7.3
Do not know	1	1.8
Total	**55**	**100.0**

For what proportion of cases does your office request additional medical information for individuals referred to you by CIC for surveillance?		
Q6	**Frequency**	**Percent**
In less than 25% of cases	20	36.4
Between 25-50% of cases	6	10.9
Between 51-75% of cases	4	7.3
Between 76-99% of cases	3	5.5
In 100% of cases	15	27.3
None	7	12.7
Total	**55**	**100.0**

Can you explain why in certain cases you do not request additional medical information? (Probe: is the information provided with the notification sufficient, or are there other reasons?)
Q7 - Open

To whom do you make the request for additional medical information? (see open ends for other responses)		
Q8	**Frequency**	**Percent**
CIC	30	62.5
The Ministry of Health in my Province or Territory	12	25.0
Other	6	12.5
Total	**48**	**100.0**

On average, how long does it take to receive the medical information that was requested?		
Q9	**Frequency**	**Percent**
Less than 1 week	7	14.6
Between 1 to 2 weeks	6	12.5
Between 2 to 4 weeks	16	33.3
Between 1-2 months	11	22.9
Over 2 months	3	6.3
Do not know	5	10.4
Total	**48**	**100.0**

To what extent do you feel that the additional medical information you request is received by your office in a timely manner?		
Q10	**Frequency**	**Percent**
1 - not at all	5	10.4
2	4	8.3
3 - somewhat	17	35.4
4	14	29.2
5 - to a great extent	7	14.6
Do not know	1	2.1
Total	**48**	**100.0**

When the additional requested information is not received in a timely manner, how does this affect your office and/or the surveillance process?
Q11 – Open ended

What additional medical information is typically requested? (see open ends for other responses)			
Q12	**Responses**		**Percent of Cases (of respondents who selected that category)**
	n	**Percent (of responses)**	
Chest X-ray	43	29.1	89.6
Laboratory test results (e.g., blood,...	29	19.6	60.4
Treatment history	37	25.0	77.1
Medical report	35	23.6	72.9
Other	4	2.7	8.3
Total	**148**	**100.0**	--

To what extent is the additional medical information that is provided, the information you need?		
Q13	**Frequency**	**Valid Percent**
1- not at all	0	0
2	2	4.2
3 - somewhat	2	4.2
4	15	31.3
5 - to a great extent	27	56.3
Do not know	2	4.2
Total	**48**	**100.0**

What are the gaps in the medical information you receive from CIC?
Q14

In an average year, can you estimate the number of recent migrants that you see in your office for TB-related issues whether referred by CIC or not?		
Q15	**Frequency**	**Percent**
Less than 5	16	29.1
Between 5-9	5	9.1
Between 10-24	8	14.5
Between 25-49	8	14.5
Between 75-99	1	1.8
Between 100-149	4	7.3
Between 150-199	2	3.6
Between 200-249	2	3.6
250 or more	6	10.9
Do not know	3	5.5
Total	**55**	**100.0**

Out of these cases, can you estimate what proportion would have been referred to you through a CIC medical surveillance notification?		
Q16	**Frequency**	**Percent**
None: 0%	1	1.8
1%-19%	5	9.1
20%-39%	2	3.6
40%-59%	2	3.6
80%-99%	19	34.5
All: 100%	21	38.2
Do not know	5	9.1
Total	**55**	**100.0**

Thinking of the recent migrants that you see for TB-related issues who were not referred to you by CIC, are you able to indicate what type of migrant comprises the majority of these cases?		
Q17	**Frequency**	**Percent**
Visitors (those in Canada for less than 6 months)	4	13.8
Students	9	31.0
Temporary foreign workers	1	3.4
Recently landed permanent residents	10	34.5
Refugees/refugee claimants	4	13.8
Do not know	1	3.4
Total	**29**	**100.0**

When your office sees a recent migrant for TB-related issues who was not referred by CIC, to your knowledge, is CIC eventually notified of these types of cases?		
Q18	**Frequency**	**Percent**
Yes	11	37.9
No	12	41.4
Do not know	6	20.7
Total	**29**	**100.0**

Thinking of the recent migrants that you see for surveillance that were referred by CIC, can you indicate your office's normal process for establishing contact with the surveillance client?		
Q19	**Frequency**	**Percent**
My office contacts the surveillance client when we receive the notification from CIC or my Province / Territory.	27	55.1
Combination of both processes.	22	44.9
Total	**49**	**100.0**

Usually, is contact between your PHU and the client easily established?		
Q20	**Frequency**	**Valid Percent**
Yes	48	98.0
No	1	2.0
Total	**49**	**100.0**

What are the challenges in establishing contact with surveillance clients that CIC has notified you of? (see open ends for other responses)			
Q21	**Responses**		**Percent of Cases (of respondents who selected that category)**
	n	**Percent (of responses)**	
Incorrect client contact information on file	21	18.3	42.9
Insufficient client contact information on file (e.g. lack of phone, email, etc.)	18	15.7	36.7
Transience / mobility of some recent migrants	22	19.1	44.9
Recent migrants are not available during PHU office hours	7	6.1	14.3
Recent migrants do not return calls/emails from PHU	7	6.1	14.3
CIC surveillance notifications are not received in a timely manner following the client's entry into Canada	6	5.2	12.2

There are no challenges	7	6.1	14.3
Other	27	23.5	55.1
Total	**115**	**100.0**	**234.7**

6.0 Site Visits – Interview Guides

6.1. Regional Medical Office – Other Staff

1. Can you describe your main responsibilities and involvement as it relates to your role in the RMO?
    a) (If question applies) Could you walk us through a typical case, so we can better understand the process?

2. What tools do you use for your job and what training did you receive?
    a) How effective are these tools and training?
    b) Are any improvements required?

3. Are there business standards (processing time standards) related to this piece of the process?

4. Are IMEs being conducted and assessed in a timely manner?
    a) Are there any particular issues that impact their timeliness *(for what reasons)*?

5. In your opinion, are IMEs being conducted consistently across the network of panel physicians?
    a) Are there any challenges with the IME process? Any areas for improvement?

6. In your opinion, are IMEs being assessed consistently across the network of RMOs?
    a) Are there any challenges with the IMA process? Any areas for improvement?
    b) [*e-medical specific question*] Are panel physicians consistently and accurately entering IME information into the e-medical system?

7. What would you say works well in this (health screening) process?

8. Have there been any changes to the program that have made operations more efficient?

9. What has been the impact of e-medical and auto clearance in GCMS? Are there any gaps/ areas for improvement?

10. Are there any issues/challenges or inefficiencies in the medical screening and assessment process?

11. Are any improvements to the current process required?

Thank you for your time and cooperation.

6.2. Regional Medical Office - Medical Officers

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe your role and responsibilities in the RMO?

Program Relevance

2.
   a) Does the health status of migrants need to be assessed before they are admitted into Canada?

   Why or why not?

   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Program Policy and Design

3.
   a) Are the policies on danger to public health and public safety still needed and relevant? Why or why not?
   b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health and public safety? Are there any gaps in this policy?

4. Is the policy on Excessive Demand still needed and relevant? Why or why not?

5. Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Management and Delivery

6. Who are the key program partners/stakeholders that you work with?
   a) What kinds of communication and coordination mechanisms are in place to manage the screening and notification components of the program?
   b) How effective is the communication and coordination between:

i. RMO and Panel Physicians/Radiologists?
ii. RMO and CIC NHQ?
iii. RMO and Visa Offices?
iv. Other?

7. What tools, training and guidance are available to support the delivery of the IME and IMA process?
    a) How effective are these tools, training, guidance, etc?
    b) Are any improvements required?

8. What procedures does this RMO undertake to ensure that panel physicians are following IME guidelines? (QA, Monitoring, etc.)
    a) Is this consistent across all RMOs? Are there any RMO-specific procedures that you follow?
    b) How frequent are these procedures undertaken?
    c) Are there any gaps / areas for improvement?
    d) How is the information compiled and reported? (reviewed at the RMO level, reported to NHQ, etc.)

9. In your opinion, are IMEs being conducted consistently across the network of panel physicians?
    a) Are there any challenges with the IME process? Any areas for improvement?

10. In your opinion, are IMEs being assessed consistently across the network of RMOs?
    a) Are there any challenges with the IMA process? Any areas for improvement?
    b) [*e-medical specific question*] Are panel physicians consistently and accurately entering IME information into the e-medical system?

11. To what extent are IMEs being conducted and assessed in a timely manner?
    a) Are there any particular issues that impact their timeliness *(for what reasons)*?
    b) To what extent do timeliness issues related to IMEs affect the overall processing of applications?

12. What changes have been made to the medical screening and notification program as a result of modernization?
    a) What has been the impact of modernization?
    b) Have there been any gaps or challenges?

Program Performance

13. Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?
    a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?
    b) Do you have any suggestions to improve clients' awareness and compliance?

14. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?
    a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

15. What do you think have been the key benefits or impact of the Health Screening and Notification program?

Resource Utilization

16. Have there been any changes to the program that have made operations more efficient?
    a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?
    b) Any suggestions to improve program efficiency?

17. Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?

Thank you for your time and cooperation.

6.3. Immigration Officers

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe your main responsibilities and involvement as it relates to the visa office and the regional medical office?

Program Relevance

2.
   a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?
   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Program Policy and Design

Applicants who are likely to impose a burden on Canadian health care or social services may be deemed inadmissible on 'Excessive Demand' if their health care expenditures are likely to be more than the Canadian average. Certain applicants such as refugees and sponsored spouses, partners, and children are also exempt from this regulation.

3.
   a) Is the policy on Excessive Demand still needed and relevant? Why or why not?
   b) Are there any challenges assessing medical admissibility with respect to Excessive Demand?

Applicants are screened for medical conditions, including active tuberculosis and untreated syphilis, which are deemed to be a danger to public health.

4.
   a) Is the policy on danger to public health still needed and relevant? Why or why not?
   b) Are there any challenges assessing medical admissibility with respect to public health?

Applicants are also screened for conditions which may pose a danger to public safety such as a variety of serious mental health conditions (e.g., sociopathic disorders, pedophilia, violent tendencies, etc.).

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?
b) Are there any challenges assessing medical admissibility with respect to public safety?

CIC screens certain applicants and populations for health-related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from examinations such as those typically visiting Canada for less than six months and those visiting Canada for longer than six months and coming from certain designated countries.

6. Are we screening the right applicants and populations of applicants? Are there any gaps?

Program Management and Delivery

7. What tools, training and guidance are available to support visa officers in assessing medical admissibility?
    a) How effective are these tools, training, guidance, etc?
    b) Are any improvements required?

8. In terms of assessing medical admissibility, who are the key program partners/stakeholders that you work with?
    a) What kinds of communication and coordination mechanisms are in place to manage the screening and notification components of the program?
    b) How effective is the communication and coordination between:
        i. Visa Office and the RMO?
        ii. Visa Office and Health Branch NHQ?
        iii. Other?
    c) Are any improvements required?

9. When an applicant is deemed to require medical surveillance, what information and guidance are available for visa officers and clients?
    a) How effective are these tools, etc?
    b) Are any improvements required?

10. What changes have been made to the health screening process as a result of modernization?
    a) What has been the impact of modernization?
    b) Have there been any gaps or challenges?

Program Performance

11. Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?
    a) What information do you provide to clients with conditions of public health significance and how is this provided?
    b) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?
    c) Do you have any suggestions to improve clients' awareness and compliance?

12. To what extent has the HSN Program:

a) Reduced the burden on the health and social services in Canada? Please explain. (Probe: How do you know this?)
b) Protected the health and safety of Canadians? Please explain. (Probe: How do you know this? Are there any other benefits of the program to Canada?)

Resource Utilization

13. Have there been any changes to the health screening process that have made operations more efficient?
    a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?
    b) Any suggestions to improve program efficiency?

14. Are there alternative ways of delivering the health screening program that would be more cost-effective and/or better achieve the program objectives?

Thank you for your time and cooperation.

6.4. Panel Physicians

The Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The evaluation is being conducted by CIC's Evaluation Division to determine how well the program is working and to understand its impacts.

CIC has developed a number of procedures and tools to support the Panel Physicians that undertake immigration medical examinations on its behalf. The questions in this guide aim to understand whether these procedures and tools support you in fulfilling your responsibilities and whether there are any gaps or improvements necessary.

The responses that you provide will be kept confidential by the evaluation team and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.
    a) How long have you been a Panel Physician for CIC?
    b) Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Procedures and Tools for Panel Physicians

2. CIC's Panel Members Handbook contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?
    a) Is the information in the manual useful, relevant?
    b) Are any improvements required?

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?
    a) Are any improvements necessary?

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?
    a) Are any improvements required?

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?
    a) How effective were these training and tools?
    b) Are any improvements necessary?

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

7. What impact has e-medical had on:
    a) The way in which you conduct IMEs?
    b) The time it takes to conduct an IME?
    c) The information that is provided to the CIC Regional Medical Offices?
    d) Other impacts?

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?
    a) Are any improvements necessary?

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?
    a) Are there any gaps in the current approach to conducting IMEs?

Thank you for your time and cooperation.

Risk to public health: The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis. Latent tuberculosis is not considered a risk, as once it is identified it can be treated without risk of infecting the Canadian population

Risk to public safety: The federal government also screens applicants for conditions which may be deemed to pose a danger to public safety. This policy typically considers a variety of mental health conditions such as clinically diagnosed sociopathic disorders, aberrant sexual disorders (e.g., paedophilia), or substance abuse issues leading to antisocial/violent behaviour.

s.21(1)(b)

INTERVIEW GUIDE - CBSA STAFF

I do not liaise with CIC on medical issues but I suppose I could, but no opportunities have arisen to necessitate that contact.

1. a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?

Yes – there's a legal requirement (IRPA). A38 1 b) c) and d) speaks specifically to this need. There are some exceptions of course outlined in IRPA as well. Beyond this there are economic realities dealing with certain conditions which would pose excessive demand on our health care system if we did not screen people.

b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Some people with certain conditions should also be placed under surveillance. Not all conditions, mind you, but I think there's a risk of infectious diseases like inactive TB becoming active again. I'm not really sure why treated syphilis is placed under surveillance but I've been explained by medical professionals that this is also a risk to the Canadian public.

2.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Yes – I don't think they are overstepping their boundary. It's correct. It's in keeping with IRPA.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes – I know the work is going on, I don't really know of the result of any gaps.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

No – can't think of anything.

3.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

I think it's relevant and needed. But it may not be flexible enough. But I'm not a medical professional. Like what would happen if Avian Flu took off – the policy may not be able to handle this.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

I'm not sure, but I wonder if our assessment process is flexible enough to catch TRs with certain conditions. I also have anecdotal information to support the view that with one-off issues such as SARS we are unable to refuse entry using this policy.

4.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

I don't know. I think the principle of preventing those to enter Canada who would pose a safety concern to its habitants is important but this policy may be a hard one to operationalize/assess. I think it's an important issue but it's not well defined and the guidance is not very specific. At the border if we see some criminal convictions for drugs, violence, etc., then we'll refuse under criminality before we try to go through this policy. If they have pedophilia on their person at the border then they'll be written up for seizure, and dealt with that way.

I'd be interested to see just how many A38 1) b) reports are actually written at the border.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Yes, I think CIC is just listening to the advice of Health Canada, so as long as medical experts are involved with this decision, then it's fine.

Is the policy on Excessive Demand still needed and relevant? Why or why not?

Yes, it's needed. ED exempt is still important for certain categories but we shouldn't place a strain on our health care system by removing this policy from everyone.

5. Are we screening the right applicants and populations of applicants? Are there any gaps?

I don't know. I think we shouldn't screen everyone, but I would like to have a system that's flexible enough to deal with someone who pops up, that we have a higher chance of catching them – as opposed to a blanket exemption.

GUIDE D'ENTREVUE – PERSONNEL DE L'ASFC

1. Pouvez-vous expliquer comment le programme de notification médicale fonctionne au point d'entrée?

Il y a deux types de personnes qui arrivent : ceux qui ont leur formulaire déjà, et ceux qui ne l'ont pas (TFW, étudiants) mais c'est important qu'ils soient suivis.

Pour les nouveaux immigrants qui ont les documents de landing et IMM0535, s'il est un nouvel arrivant au Québec, le Ministère de la Santé va le contacter dans les premières semaines. Dès leur arrivée à l'aéroport,l'agent de l'ASFC leur indique qu'ils seront contactés par la province (Ministère de la santé).

Pour ceux qui n'ont pas de formulaire déjà complété :
Et qui seront au pays pour une période de plus de 6 mois : il est nécessaire de voir quels pays ils ont visité dans la dernière année et à ce moment on détermine si un examen est nécessaire. Ceci est plus fréquemment avec les TFW et les IS. Il faut aussi s'assurer qu'il ne s'agit pas d'un emploi qui requiert un examen de santé (par example, les travailleurs qui prennent soins des enfants, ils doivent compléter les examens médicaux, ou encore certains étudiants, ceux qui étudient en médecine ou études de la santé qui ont besoin d'un examen médical pour leur étude.

Pour ceux qui ont le formulaire déjà complété :
L'ASFC complète le formulaire avec le nouvel immigrant si celui-ci l'a perdu ou oublié. L'aspect le plus problématique est d'obtenir les coordonnées (très souvent, ils n'ont pas d'adresse au pays). On les informe que le Ministère de Santé va les contacter, mais si l'adresse n'est pas complétée c'est difficile. L'agent de l'ASFC remet un pamphlet/dépliant sur l'importance de la surveillance médicale à la personne. Les personnes doivent signer qu'ils acceptent les conditions de ce formulaire médicale.

Deux commis de l'ASFC envoie les formulaires complétés à CIC 2 fois par semaine, ou si le volume est trop important, les commis font plusieurs envoies. (En général l'ASFC envoie 15 à 20 formulaires par semaines)

2. Quels sont les outils, la formation et les lignes directrices dont dispose l'ASFC pour appuyer la mise en œuvre de la composante notification de surveillance du Programme de DMN?

La formation *: l'information médicale est intégrée avec la formation générale, de base des agents. L'information qu'ils recoivent est plus générale parce qu'ils n'y a pas beaucoup de temps dévoué à cet aspect durant la formation de base. Durant cette formation, on survol la LIPR (IRPA) et il y a un chapitre sur l'examen médical. L'information qu'ils obtiennent est comment remplir les formulaires. Il y a plusieurs cohortes de formations/agents et certains agents non pas la même formation, mais ils essayent que les grandes lignes soient les mêmes.*

Les outils *: Guide NF4 indique l'exécution de la loi et le contrôle aux points d'entrée. Il y a un sous-chapitre avec les exigences médicales. Il y a aussi un guide pour les agents d'immigration à l'étranger qui est utilisé par les agent de l'ASFC afin de mieux comprendre comment l'examen médical se fait à l'ambassade. Le guide pour les travailleurs étrangers (FW1) indique dans quelles circonstances les travailleursétrangers doivent se soumettre aux examens médicaux. Les bulletins opérationnels indiquent les procédures et la législation.*

Évaluation du Programme de dépistage médical et de notification

a) Dans quelle mesure ces outils, cette formation, etc. sont-ils efficaces?

C'est très efficace, et ils sont très à l'aise avec la mise en œuvre des examens médicaux. Par contre, lorsqu'il y a des cas hors norme, cela rend le travail des agents beaucoup plus difficile quant à la décision à prendre (de laisser entrer ou non une personne au pays). Si une personne doit complété un examen médical en raison de sa situation X, on ne sait pas combien de temps il faudra pour prendre un rendez-vous par ex, combien de temps il faudra attendre avant de recevoir les résultats, etc.

b) Des améliorations sont-elles nécessaires?

La connaissance de processus est clé dans le processus décisionnel de l'agent. Ils doivent mieux connaître en quoi consiste l'examen médical et les délais associés – leur connaissance est très vague. On ne veut pas refuser l'entrer d'immigrants parece que nos agents ont un manque d'information – manque d'information sur le processus.

3. Dans quelle mesure l'échange d'information entre l'ASFC et CIC est-il efficace (p. ex. transmission des formulaires IMM0535)?

a) Y a-t-il des normes (c.-à-d. en ce qui concerne les délais et l'exactitude) ou des mécanismes en place pour faciliter l'échange d'information entre l'ASFC et CIC? Quels sont-ils? Les normes établies sont-elles respectées?

Mise à part la transmission des formulaires, il y a de l'échange d'information concernant tout changements à la loi (IRPA) à son application ou aux processus (via OPs et OBs). CIC nous envoie l'information concernant tous ces changements. CIC envoie les modifications au niveau de procédures de CIC, les changements d'application de loi.
Au Québec, à Montréal – les formulaires IMM0535 sont envoyés deux fois par semaine.
La transmission des formulaire va très bien. Le gouvernement du Québec doit contacter la personne (et non l'inverse comme dans les autres provinces). La rapidité dans la transmission de ces changements de la loi, est nécessaire, afin de permettre suffisamment de temps pour informer les employées en raisons des heures de travail variables des agents.Afin d'informer tout le monde (près de 300 officiers), il faut donner suffisament de temps. En communiquant avec les agents, une norme nombre de jours de communiquer par courriel avant que c'est officiel est nécessaire pour les agents qui sont sur une rotation. Souvent les gens sont en formation, et chaque agent ne voit pas les courriels.

Oui, l'échange d'information est efficace pour l'envoie des formulaires, il y a un bon rythme,ils sont envoyé fréquemment mais ils n'ont jamais eu de feedback de CIC.

b) Que recommanderiez-vous afin d'améliorer l'échange d'information entre l'ASFC et CIC?

Quand il y a des changements implicant les POE ,il est nécessaire de les communiquer (rapidement) quelques semaines en avance, afin de pouvoir informer tous les agents. Il y a plusieurs intervenants/agents et il y a des conséquences pour les immigrants si tous les agents ne sont pas au courant.

4. Aux points d'entrée, les clients sont-ils informés de façon efficace et systématique quant à leurs responsabilités en matière de surveillance?

Oui – La majorité des dossiers sont les nouveaux immigrants/résidents temporaire. Au Québec, les personnes seront contactées par le ministère de la santé. Une très grande majorité comprend les conditions que vous avez donné – ils savent que c'est un contrat avec CIC qu'ils doivent respecter. L'information que les agents doivent fournir est minime : ils doivent s'assurer de communiquer l'information; rendre le dépliant aux immigrants; et s'assurer que les gens comprennent leur

engagement vis-à-vis leur suivi médical. L'information est bien communiquer par les agents. Les personnes ont beaucoup de questions, mais les immigrants ont bien compris l'importance de faire le suivi medical.

a) Quels sont les défis que l'ASFC doit relever pour s'assurer que ces personnes comprennent la nature de leur condition médicale et qu'elles respectent les exigences en matière de surveillance?

Les défis ne sont pas à au niveau de la compréhension – ils comprennent tres bien. Ou il y a plus de problèmes c'est avec le processus pour la province du Québec – ils comprennent que c'est différent dans les autre provinces. Québec c'est l'inverse – Ce sont les autorités de la santé du Québec qui contactent les immigrantss. Le plus grand défi est de capter leur adresse au Québec ou même de l'information pour les rejoindre. On n'a pas d'adresse, ou de coordonnées pour les rejoindre. Ils ne sont pas en mesure de nous donner de l'information sur comment et où les rejoindre une fois au Québec. Mais s'il n'y a pas une adresse, c'est difficile d'entrer un adresse pour le ministère de la santé. Donc il y a un délais pour la surveillance médicale. Un autre défis est celui de la barrière de la langue. C'est difficile de communiquer avec certains nouveaux immigrants puisqu'ils ne comprennent pas le français (ou même l'anglais).

Ils n'ont pas un adresse, mais ASFC a besoin d'un adresse pour la formulaire de surveillance. C'est important que les personnes aient une adresse avant d'arriver. Ils ont besoin de pourchasser les personnes pour aller au docteur. Aussi, il ya une barrière de la langue, les personnes âgés, etc.

Le processus pour le Québec est différent tel qu' indiqué dans les guides : NF4 2.11, OP15

Quand il y a un changement d'adresse : 80 jours délais, SMJC – il voit les changements s'ils contactent CIC.

b) Y a-t-il des lacunes dans les renseignements qui leurs sont communiqués?

C'est beaucoup d'information pour les personnes qui arrivent dans un nouveau pays. Trop d'information dans un cours laps de temps pour eux. De plus, ils sont nerveux, exciter, c'est un longvoyage qu'ils viennent de faire (puisque les agents en questions sont ceux de l'aéroport de Montréal), etc.

c) Avez-vous des suggestions qui permettraient de mieux sensibiliser les clients et d'accroître le taux de respect des exigences?

Au niveau des immigrants, on fait la sensibilisation et on dit ce qui doit être dit. Auparavant, les consultants/avocats en immigration connaissaient les résultats des tests médicaux, maintenant ils ne sont plus informés et du même coup plusieurs immigrants ne sont pas informés.

5. Selon vous, le Programme DMN s'harmonise-t-il avec les priorités du gouvernement du Canada? De quelles façons le Programme s'harmonise-t-il ou non avec ces priorités?

Oui, pour protéger la santé et la sécurité de Canada. Et pour assurer qu'ils n'apportent pas 'excessive demande' dans le système canadien.

6. Les demandeurs dont l'état de santé pourraient poser un risque pour la santé publique doivent-ils faire l'objet d'une surveillance médicale à leur arrivée? Pourquoi?

C'est impératif afin de s'assurer que le suivi suivi et le traitement soient appropriés–

INTERVIEW GUIDE - CBSA STAFF

1. Can you please describe how the medical notification program works at the Port of Entry?

In Calgary we're mostly dealing with people landing for PR. So when someone arrives with a surveillance form we review the medical conditions and surveillance requirements listed on their letter. We make sure they have the form in their possession. A lot of the time (25% of the time) people don't have this form so if they don't have it on them, we will complete it at the POE. We catch these people because their need for surveillance (code) is also listed on their CPR.

The officer at secondary ensures the address and contact number is updated. Sometimes it does seem like the address is of a family member or a friend but these addresses do get updated again later on when they go get their PR card so FOSS should have their correct address. We provide them with a copy and the other copy of the surveillance form is sent to Ottawa. We had information forms to give to them before but I'm not sure if we give them any information anymore. We basically tell them that they will be contacted by a government health official soon after they land to set up an appointment.

The surveillance forms are sent to CIC. Our numbers aren't high enough for them to be sent out daily, so we courier them about twice a week.

2. What tools, training and guidance are available at CBSA to support the delivery of the Medical Notification component of the HSN Program?

Some information is provided on the CBSA website. When we get new officers, we teach them how to land and medical screening is one of them. They have to all take cross training courses and partnering with more experienced officers for at least 2 months.

a) How effective are these tools, etc?

Yes, the process is pretty straight forward.

b) Are any improvements required?

No. There are likely improvements in terms of what is happening once people are in the country, but that's not our responsibility at that point. In meeting with some local health authorities here a few years ago there seemed to be some disconnect between the national and local efforts.

3. How effective is the information exchange (e.g., sending IMM0535s) between CBSA and CIC?

From what I understand, I believe it's working effectively.

a) Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information between CBSA and CIC? What are they? Are the established standards being followed?

It's supposed to be done once daily but we do it as they come in so this translates to a couple of times per week because we don't receive many cases.

b) What would you recommend to improve the exchange of information between CBSA and CIC?

If the sending process could be streamlined and done electronically, that could probably help to improve the process. There should also be something on their landing information (as yes/no box) that indicates whether the individual was informed of their conditions and requirements.

4. Are clients being effectively and consistently informed of their responsibilities for surveillance at POEs?

Some of the time (maybe 20% of the time) the person at the POE is not aware that they even have a medical surveillance form, or why they need it. Some don't know anything about their condition, which places us in an interesting situation of telling them at the border of their medical condition and their need to undergo surveillance.

a) What challenges does CBSA encounter in making sure that individuals understand their medical condition and comply with surveillance requirements?

The chief issue is language issues. There's also a question of privacy of information in terms of language issues because they will often have someone there (a family member or friend for example) who is acting as a interpreter – so the question arises as to how much they should know about the medical history of the newcomer. There's also a certain percentage of people where no matter how much information you send them, they won't read it; so we can't really do much in these situations.

b) Are there any gaps in the information they receive?

I haven't seen any info sheets at the visa offices. You should send some information with the visa form. The conditions should be clearly outlines – I think I've seen these forms but they're only in English and French.

c) Do you have any suggestions to improve clients' awareness and compliance?

If information sheets exist for different conditions, we would have no problem in giving these out. If they're being notified of the relevant issues by the visa office before they arrive and again at the POE, I'm not sure what else we can do. There's also an amount of onus on the immigrant to investigate and understand the material they are being presented with.

5. Do you feel that the HSN Program aligns with the priorities of the Government of Canada? In what ways does the Program align/not align?

Yes. Some people new to the program may not understand why we are letting in people with inactive TB, so maybe we should educate people a bit better about that, but it does align with GoC objectives of safeguarding Canadians.

6. Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Yes, what I said before is also the primary reason to place people under surveillance. Although, I'd like to see the impact of surveillance and how effective it's been at tracking these cases and how many people reactivate.

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE - CBSA STAFF

1. Can you please describe how the medical notification program works at the Port of Entry?

Having said that the process is as follows:

Someone arrives at the POE with a surveillance form at primary. They present themselves with their documentation which indicates to the officer that they need to be assessed further. At post-primary they enter one of two lines, either for landing or permits holders/applicants. At secondary they present their medical surveillance form. The officer would then conduct a FOSS check on the individual, updating any bio data and the surveillance form would be reviewed at this point. Often the individual just hands over a pile of papers, not knowing what it is that the officer is looking for.

In picking out the surveillance form, this would indicate to the officer what kind of medical concern is involved. Usually, it's inactive TB that we see a lot of, so we would then tell the applicant about their requirements in connecting with a local public health official within the initial 30 days upon entry. Sometimes the requirements are more stringent (i.e., they have to contact PHU within 7 days) and so we notify them of this. It's a matter of regular protocol that we would go through these steps and officers are trained for this.

The surveillance forms then get batched in the same voluntary compliance area and once daily, or some other period of time (I'm not sure as I don't work in that unit), they get sent to CIC by administrative staff. You would have to speak with TSR for further specifics.

2. What tools, training and guidance are available at CBSA to support the delivery of the Medical Notification component of the HSN Program?

In addition to standard training and workplace guidance/supervision, we have copies of the contact information for where clients need to report once landed. Most have this form already.

a) How effective are these tools, etc?

Yes. I haven't come across any misunderstandings or issues.

b) Are any improvements required?

I would be interested in knowing the extent to which those who land actually do get connected with the proper health authorities. We only spend a minor amount of time with each client. There are some cases (mostly unintentional I think) where people neglect to show us the surveillance form. But 99% are coming for a CPR and the surveillance is shown on this document.

3. How effective is the information exchange (e.g., sending IMM0535s) between CBSA and CIC?

a) **Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information between CBSA and CIC? What are they? Are the established standards being followed?**
b) **What would you recommend to improve the exchange of information between CBSA and CIC?**

TSR would be best to answer these questions. You should refer to them.

4. **Are clients being effectively and consistently informed of their responsibilities for surveillance at POEs?**
    a) **What challenges does CBSA encounter in making sure that individuals understand their medical condition and comply with surveillance requirements?**

We encounter a lot of language barriers. So we often have to use interpreters (Cantonese, Mandarin and Punjabi). We usually have someone on site.

    b) **Are there any gaps in the information they receive?**

They have the right amount of information – no gaps.

    c) **Do you have any suggestions to improve clients' awareness and compliance?**

Improvements can be made in the way that the information looks – so a more easily understandable pamphlet. What they essentially receive is a batch of papers with government language. So something a bit more user-friendly may be helpful to them – possibly in different languages.

5. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada? In what ways does the Program align/not align?**

Yes, absolutely. It's a means of safeguarding Canadians which is a priority for the GoC. Also from an economic point of view, in terms of excessive demand it aligns well.

6. **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes I believe that it is needed, though I don't know the end result – how many people actually comply.

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE - CBSA STAFF

1. Can you please describe how the medical notification program works at the Port of Entry?

I have to admit that I have very little experience with this program. I haven't seen many cases requiring medical surveillance. I did canvas a few other officers here and they also don't really deal much with this program.

When someone arrives at the POE, we examine all their papers and their intent. If we find something requiring a secondary inspection (i.e. if they are landing or if there's a medical form 535 or they indicate as such) then we would examine them further. At secondary their surveillance form would be taken and they would be provided with the place to contact once they are in the country. We have a list of health offices. We would then fax the surveillance form to CIC once or twice a week. While at secondary, the CBSA officer would also ensure to update the contact information of the client.

2. What tools, training and guidance are available at CBSA to support the delivery of the Medical Notification component of the HSN Program?

There's an OB 340 which explains the procedures we undertake with these clients. We have the form 535 in case the client doesn't have it with them and they have to complete it at the border. We have a list of public health offices. We have CBSA and CIC manuals.

a) How effective are these tools, etc?

I think so.

b) Are any improvements required?

Not sure.

3. How effective is the information exchange (e.g., sending IMM0535s) between CBSA and CIC?

Not sure. Like I said, I don't send these forms very often. Also, CIC doesn't really communicate with us once a form is sent out. The information exchange is one way. We fax the forms and I'm not sure of any issues.

a) Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information between CBSA and CIC? What are they? Are the established standards being followed?

I believe we have to fax the forms within a day of receiving them.

b) What would you recommend to improve the exchange of information between CBSA and CIC?

No comment.

4. **Are clients being effectively and consistently informed of their responsibilities for surveillance at POEs?**

Yes, but they don't always understand.

   a) **What challenges does CBSA encounter in making sure that individuals understand their medical condition and comply with surveillance requirements?**

There are major language issues among many clients we see. We do have interpreters at our disposal so I think that helps. Sometimes there are clients who just don't understand or care to understand.

   b) **Are there any gaps in the information they receive?**

I remember seeing some pamphlets but I don't think we have them anymore.

   c) **Do you have any suggestions to improve clients' awareness and compliance?**

I think it would be beneficial to have these pamphlets in other languages (other than Eng or FR). We can certainly hand out any information given to us.

5. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada? In what ways does the Program align/not align?**

I don't have an answer for that.

6. **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes, I think so - for reasons of ensuring safety and health of Canadians. However, I just see so few of these cases so I don't know if the effort is worth it. For example, I can't remember hearing about even on in the last few months.

Pages 117 to / à 119
are withheld pursuant to section
sont retenues en vertu de l'article

13(1)(c)

of the Access to Information Act
de la Loi sur l'accès à l'information

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE – Chief Medical Officers of Health (P/Ts)

1. Can you please describe your current role as it relates to health, immigration, or infectious diseases?

xx

Program Relevance

2. a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?

   xx

   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

   xx

3. *As you may be aware, the role of the federal government in the HSN Program is to facilitate medical examinations for clients through local panel physicians; conduct medical assessments for immigration purposes using the results of medical examinations; identify applicants who require medical surveillance in Canada; and notify provincial/territorial health authorities of the presence of individuals requiring surveillance.*

   a) Considering each of these federal responsibilities, is the federal government's current role appropriate:
   - In facilitating medical examinations and conducting assessments?
   - In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?

xx

Program Policy and Design

4. *The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis.*

   a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

   xx

   b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

   xx

5. *CIC screens certain applicants and populations for health related admissibility such as those applying to immigrate, study, or work in Canada. Some clients are exempt from medical examinations such as those typically visiting Canada for less than six months.*

   a) Are we screening the right applicants and populations of applicants? Are there any gaps?

   xx

Program Performance

6. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

   a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

   xx

   b) Are there any data available on active TB cases within in the immigration population in your province or territory?

   xx

   c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

   xx

Resource Utilization

7. Are there any overall or general improvements to the HSN Program you would recommend?

   Xx

Thank you for your time and cooperation.

Pages 122 to / à 147

are withheld pursuant to section

sont retenues en vertu de l'article

13(1)(c)

of the Access to Information Act

de la Loi sur l'accès à l'information

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INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

I provide policy and strategic advice to senior managers in my division and CIC. I work on existing policy changes and have a coordination role with other departments such as PHAC and CBSA. I liaise with them from time to time about CIC's approach to public health issues (e.g. recent polio outbreak in Syria).

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes. By identifying health risks, CIC can manage these risks better. There is a benefit to Canadian society, our clients, and migrant communities in Canada given that migrants live in close communities in Canada. Also, some risks need to be identified prior to arrival.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes. It's more appropriate to look at certain conditions once someone arrives. It allows us to admit people and not deny them entry (which is an extreme decision) for those who have lower risk conditions. It's about risk mitigation.

There are public health risks. PTs don't put people into quarantine who have these risks so there needs to be surveillance. By identifying TB/Syph CIC can then make PTs aware of their arrival. But we must link to PT system. It would be nice to have conversation with the PTs.

Right now there are bilateral communications with PTs. There is a council of medical officers as well which PHAC sits on and CIC acts as ex officio. These meetings are regular (I believe held once a month), which is attended by Dr Grondin. There are also ad hoc meetings with PTs but there's no consultation strategy that has been formalized. We provide information items and update but we also get random contacts through email or phone regarding particular diseases.

3. **a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:**
   - **Facilitating medical examinations and conducting assessments?**

Yes, it aligns with federal role in terms of selection and facilitating entry. Fed role to protect health and safety of Canadians. The PPs are a managed network; managed by us (the federal government) which sets the Canadian standards on health. This role is appropriate.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes. Like I said before it aligns with selection and integration goals of federal government so it should be a part of our role. Our key role is linking the client with the PT. CIC should ensure that our role ends with the linking part. PTs all have various approaches to how they require surveillance (and to what degree)

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

In 3b, I identified two additional responsibilities as part of the federal role:

- *A. Identifying migrants at risk for chronic illnesses so that health-related integration supports can be provided (whether they be provided at a federal or P/T level) – for the purpose of promoting long-term health, and*
- *B. Describing health profiles of migrant source countries and sharing those profiles with P/T health partners to facilitate the delivery of health-related integration supports – again for the purpose of promoting long-term health.*

What I'd like to add is why I think this should be a federal responsibility.
We have evidence showing that most migrants arrive in Canada with better health than the Canadian population. But we also know that the health of immigrants (on the whole) declines over time and we know that immigrant populations are more susceptible, compared to the Canadian population, to certain chronic illnesses. We know, for Canadians as a whole, that certain chronic illnesses (e.g. mental health) negatively impact the economic outcomes. We don't know if this is true for immigrants (another data gap). To the extent that immigration is viewed as a means to address labour needs, there is value for the federal government in identifying individuals (A. Above) or populations (B. Above) at risk for chronic illness in the long-terms. Identifying such people, and sharing this information with our P/T partners, would facilitate P/Ts to prevent or manage chronic illnesses (and thus maximize their contributions to the labour force) through interventions such as health promotion and early detection and treatment. Given our role in selection and integration, the step of identifying at-risk migrations should be our responsibility.

CIC should limit its role to identifying migrants needing health related integration support for promoting long term health care. Right now the migrant lands and contacts PTs who triage these clients. Some PTs, for lower risk cases (say inactive TB) may do not anything more. For our purposes, the client has fulfilled their surveillance requirement once they meet the requirements set by the PTs (who contact us with information regarding their fulfilment). CIC doesn't have a systematic process to identify when the client has met their condition so our role should be limited to just the linkage part.

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes. Active TB is easily spread, difficult to treat, and costly to treat. It results in death and ranks high on the list of communicable diseases. There is a real danger to Canadians so we should have this policy.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

There are some changes coming forward following recent review of this policy. We need the policy to be more flexible. Not just a list of two diseases, but a list of factors of what dangerous conditions look like.

I'm not quite sure why syphilis is included specifically in the current policy. It is there historically. We did recommend to drop this condition from the policy but we received push back from some PTs. I suppose they felt there were still instances of this disease in their provinces to warrant it. If we weigh the consequences of syphilis, we would think about other diseases too, which aren't on the policy. Maybe syphilis is not a big threat anymore.

Syphilis is a sexually transmitted disease which has an element of human behavior, so we could be doing more to provide education on sexual practices, etc.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

Yes. We didn't identify a list of diseases. There are a number of conditions, including mental health issues and display of behaviors that would pose a threat to others. The assessment is case-by-case, based on this policy. It is more difficult to collect information about this behavior and we detect much less of these kinds of cases, as a result. We don't really have data on the cases that we missed, but the ones we catch would potentially pose severe consequences on the Canadian public if we didn't catch them [or if there was no policy on this] so it's really about comparing these benefits against how much work we do to examine and assess for these cases.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Yes. The conditions and factors listed are appropriate, in my opinion. I am a bit biased on this because I was part of the team that helped to draft this policy. No gaps I can think of.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

This is a big question mark for me. There's a real risk of demands on the health care system; PT health care systems are strained, so identifying cases that would pose excessive demand would reduce the burden on our health care system. So there is a clear logical rationale for this policy.

BUT: The benefits/costs are just for the PTs since they are the ones that pay for health care in the provinces. It is also recognized that [despite their costs] migrants can also bring advantages and benefits to PTs. We [CIC] need to check in with PTs about this. CIC looks after admissibility so it's in the officer's discretion to interpret the policy.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

I suspect no, but I really don't have any post arrival data on people who aren't screened and how many develop conditions. But looking at TB data, we find some people do develop active TB a year after arrival so

I'm not sure where the problem resides, in the surveillance or not finding these people through screening, or not screening them.

The country list for medical screening is based on TB rates around the world; it doesn't have to do with other conditions, so in certain countries the TB rate could be low but they may have high incidences of another condition which we should care about [Hep, Polio, Gonorrhea, etc.].

There is also no linkage between the policy movement on the policy on danger to public health/safety and the designated countries list.

Examinations for excessive demand also doesn't make much sense in terms of TR applicants since the PTs don't pay for their health care coverage. They need to demonstrate private insurance or personal funds so ED is not really appropriate to consider. So in terms of ED, we're not screening for the right people

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

I know there are manuals for PPs, there are OPS manuals. HB has made inroads to standardize tools, training, and guidance. There is systematic training for MOFs.

   a) **How effective are these tools, training, guidance, etc?**

Not sure.

   b) **Are any improvements required?**

Not sure.

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

I know CBSA officers have procedures and manuals. I don't have much to say on this.

   a) **How effective are these tools, etc?**

No comment.

   b) **Are any improvements required?**

No comment.

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?**

I mentioned previously the communication and coordination mechanisms in place with the PTs, but I don't think they are "delivery" partners of the Program. In terms of with CBSA, there's a MoU which

covers broadly cooperation and communication between the two departments. In the MoU there are annexes referencing shared services and one of those shared services listed is medical surveillance.

a) **How effective are these mechanisms?**

On the surveillance side, sometimes people don't follow through. Some travel repeatedly. Visa officers will renew visas despite HB notes. I suspect that they sometimes [when doing TR applications which are done quickly] don't click on the screen for NSB notes. NSB notes are additional notes in the system on a file on anything noteworthy, like medical concerns/issues.

b) **Are there any barriers?**

c) **Are any improvements required?**

11. **What changes have been made to the medical screening and notification program as a result of modernization?**

eMeds is the main modernization.

a) **What has been the impact of modernization?**

Not sure the impact of eMeds.

b) **Have there been any gaps or challenges?**

There really hasn't been any modernization to notification. This process should be covered in GCMS. The process has broken down. There are two lines at the POE. At primary, the officer doesn't really look into the applicant in terms of GCMS and meds. We inform the client to present themselves and their surveillance requirements at the POE, which means they would then be sent to secondary. So they have to go to secondary before CBSA can note their need for surveillance back to CIC and provide the client with instructions. Even at secondary, the CBSA officer doesn't always see the screen with medical instructions to relay to the client. If they do, It's a paper process at that point. CBSA informs CIC and then we inform the PTs.

12. **Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?**

Some are not aware because the instructions aren't given at the POE (I already mentioned the problems there).

a) **What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?**

Did not ask.

b) Do you have any suggestions to improve clients' awareness and compliance?

Modernize the notification/surveillance element.

13. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

We don't have any evidence on the full effectiveness since we don't know how many we miss. PHAC may know some of this information and I believe the PTs have done some research but they aren't always willing to share this with the federal government. It should start with a conversation with the PTs. CIC should decide on the level of commitment to evaluate our programs.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

Did not ask.

14. **To what extent has the HSN Program:**

a) Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How do you know this?)*

Again, we can show # we don't admit, which we can use to calculate cost savings on the health care system.

b) Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this? Are there any other benefits of the program to Canada?)*

Did not ask.

15. **Have there been any changes to the program that have made operations more efficient?**

Did not ask.

a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?

Did not ask.

b) Any suggestions to improve program efficiency?

We only have 1 data analyst for notification, which is a key resource, and it has remained unfilled for several months. This position should be filled.

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

On the ED side. I think it's possible to improve on this policy. PTs should be the ones to decide whether the policy is important.

s.21(1)(b)

INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

Follow up question: How did the training for physicians go? Did they like it? Did it work well?
We didn't receive any feedback on the training but definitely got questions once they started using the system. Some folks were more pragmatic and just got used to the system while others were more resistant and needed more assistance to transition.

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes – according to IRPA people must be assessed for admissibility.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes – surveillance also ties into IRPA. We protect newcomers and their families, as well as Canadians overall by doing follow up.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Not able to comment

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes – this falls under the mandate to protect health & safety. It is operational and reflects the bigger mission and vision of the Department.
Follow up: Is the division of roles appropriate?
The way the system is built, PTs do health care and it is done differently in each PT so it makes sense that surveillance is done by PHA/PT

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

No comment

4.

a) **Is the policy on *danger to public health* still needed and relevant? Why or why not?**

There has been work done on this but I don't know very much about it because I haven't been involved.

b) **Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?**

It is hard to comment on gaps – I'm not a doctor (I have health field training but not an MD) so it's hard to say whether there should be more or different conditions looked at.

5.

a) **Is the policy on *danger to public safety* still needed and relevant? Why or why not?**

Question asked - no comment

b) **Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?**

Question asked - no comment

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

Question asked - no comment

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Question not asked (not the right person – very operational)

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

Question not asked (not the right person – very operational and could comment on notification or e-Medical only)

a) **How effective are these tools, training, guidance, etc?**

Question not asked

b) **Are any improvements required?**

Question not asked

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

In PHLU we have MSUCM (database with profiles, etc) so we can search for clients, bio-data, and surveillance information (has immediate identifiers with all the dates relevant for PHLU and PHA related to compliance). This is completely internal. We don't deal with panel physicians directly.

Follow up question: What about CVOAs?

We don't tend to get questions from visa officers, it's more the health authorities. Sometimes we get questions from Citizenship officers about proof of compliance if someone has a note on their record. We use GCMS, FOSS/CAIPS but we also have our own little internal databases: ie. we track PT requests for copies of medical files and we have service standards to get back to them, and binders where we keep track of that. The requests are for the health care providers because they want to see the IMEs and copies of the x-rays. Claire will know about the consent issues; they do sign prior to the IME and also there's a consent/declaration form for the IMM 535 related to information sharing.

a) How effective are these tools, etc?

The program assistants use MSUCM daily [It sounded like she meant that the database was effective]

b) Are any improvements required?

Question asked, but led into question #10 below

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?**

Also follow up question from #9b): Are there any directives you provide to PTs about surveillance?
PTs are not obligated to send compliance reporting (it is built on rapport, relationships, etc)
PTs need to understand the process because it is different from theirs, however there's no formal table
NAPMED (sp?) surveillance inbox is monitored daily and some PTs will talk directly with our manager (Claire)
Also we hold ad-hoc teleconferences on specific issues and Claire has done a number of these with PHAs as well as a few site visits to do presentations.
Follow up question: What types of issues would you hold a teleconference or site visit to address?
Mostly it is to give a general overview for clarity: how we refer, our process. There are always new people on staff and our way of doing things is different than PTs so it is good for them to get familiar with our methods. Surveillance from a CIC perspective is the date of first follow up visit – this means "compliance" for us (all we are legislated for). This is not the same as the PT idea of surveillance because their perspective means a much longer time frame – thus, it's important to have that discussion.

a) How effective are these mechanisms?

It's hard to say because nothing is official.

b) Are there any barriers?

To non-compliance? There are no statistics on reporting and the process for sending the forms in is different between PTs. Enforcement is an issue.

c) Are any improvements required?

Rapport is really important and heavy, regular interaction is required. Offering teleconferences and going in person on a more regular basis would be good. Would be nice to be able to follow up or have an enforcement mechanism.

11. **What changes have been made to the medical screening and notification program as a result of modernization?**

[NB: She was not clear on what we meant by "modernization"]
Notification did not have a lot of modernization impacts. With e-Medical and GCMS we can access files electronically so there is a positive impact on PT requests. Sometimes this means we can do requests almost automatically (just print and make copies), but when the record is not electronic it can take forever to get the paper (because it is sent by diplomatic bag or courier).

a) What has been the impact of modernization?

For the notification process not much has changed. We're not integrated [with GCMS] so the main system is MSUCM, which is the same (hasn't changed). It's really access to files (when PHLU gets GCMS).

b) Have there been any gaps or challenges?

Right now over 100 countries (between 105-110) are using e-Medical but there are more to come.

12. **Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?**

If they have medical exam overseas they get a handout with IMM 535 including information about TB and/or syphilis. If in Canada they get a letter that includes the handout. This handout/pamphlet has been translated into 6 or 7 languages (most often used: Tagalog, Urdu, etc) so that visa officers can give it out to people in a language they understand. It is available on the intranet in different languages, and CBSA has access to this as well. On the internet, publicly available, it's available in English and French.

Barbara explained the process:

There are two ways the process happens –
1) overseas they get the IMM 535 2) in-Canada they get a letter (newcomers should be told that they must ask their health care provider to send proof of compliance)
Some PTs have asked CIC for a template for compliance, while others have their own. If in-Canada, the letter the newcomer receives has a section for indicating compliance.

Follow up question: Is there visa officer training or directives?

Not sure what has gone out in that respect. Regional medical officers were made aware but not sure about any training for them. The managers discussed this with CBSA and we updated OP15 manual, which now provides detailed instructions on how to fill out an IMM 535.

a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?

We are dependent on the POEs and CBSA to forward us the IMM 535s. We have had meetings to discuss and review the process. We receive some forms daily but not 100% and those that we receive are not all on time (they are supposed to send them within 24-48 hours and they are sometimes late). We don't talk to clients directly so it's hard to know their level of understanding. We get very few questions directly from clients.

b) Do you have any suggestions to improve clients' awareness and compliance?

Occasionally we'll get letters/faxes from clients asking why they need to go again. One misunderstanding is between the IME and the surveillance follow-up medicals. We had changed the letter a couple of years ago to make this clearer to clients in plain language.

13. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

Question not asked

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

Question not asked

14. **To what extent has the HSN Program:**

a) **Reduced the burden on the health and social services in Canada? Please explain.** ***(Probe: How do you know this?)***

It is an admissibility requirement – if we look at those not ED exempt there are people who are not admissible, so we reduce the burden.

b) **Protected the health and safety of Canadians? Please explain.** ***(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

The same logic applies here. We know that active TB is contagious and air borne so if people aren't admitted until they're treated we prevent the spread of TB in Canada.

15. **Have there been any changes to the program that have made operations more efficient?**

Not really sure where this info should go – Barbara mentioned this at this point in the interview but it's not about changes, it's about type of notification

Notifications to PT for purposes of HIV – there is a monthly report but the clients are not required to report for surveillance, however if a client tests positive they get post-test counseling. [This is a courtesy notification to PTs – they don't do much with it except for have the stats (epidemiological)]CIC has the notification policy for certain classes of immigrants and that's not surveillance (i.e. partner notification for family class applicants).

Recently we have gotten access to the Cognos environment so it's less time consuming to report things.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

Staff turnaround is an issue. We had 3 program assistants last year when I left and now those people are gone. Last couple of years there has been a high turnover because staff are not indeterminate but people have retired or are on extended leave.

b) **Any suggestions to improve program efficiency?**

Question not asked

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

If we can have access to files electronically it saves the cost of couriering files and saves time.

Other questions:

1) Are we able to get access to MSUCM data?

Barbara will get in touch on this, Claire does regular reports so they should be available

2) Do we have stats on requests from Citizenship officers?

Don't think there is a spreadsheet. We recently re-organized the inbox folders so this would require the person who answers to copy the email response to the right folder. To search the results it would definitely require proper email management and this is not certain. We track requests from PTs so we can say how many and how long they took to respond to, but NARMED is not tracked. Any PT requests that landed in that inbox would be re-routed and the most requests are PHAs very rarely any from visa offices or clients.

INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

I will do more liaising with other sectors of public health depending on the direction the Branch takes. If we decided to do surveillance on something else, it will be more.

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes
Canada has a high level of healthy population and to protect them and keep that status it's important to keep screening for diseases of public health significance. People come from different cultures and have different levels of care and different levels of knowledge about disease communicability.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes
For the same reasons as above; it's related to public health & public safety. Also, to protect our health system overall because with respect to financing people can come here with no insurance and then get treatment which may take services away from a Canadian who needs it.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

I think it is – it's a port of entry to the Canadian system. Many people come here but don't know where to go for health care and so the federal level has the role to do the first level of screening

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes it is – because who would do it if we were not there. For any institution in Canada – at what level would the connectivity occur if not at the federal level? Then we distribute to the PTs.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

To integrate health to the immigration context is tough. People don't realize their responsibilities re: Ts&Cs of entry to Canada. Maybe we should have enforcement role but what would that be? A fee, or a fine? Maybe we would only give PR status once proof of compliance had been given? Maybe we need to look at a re-design but what are the complications of such a system? Aside from TB we are redefining "danger to public health" definition so maybe the new definition will mean that more diseases need to be screened. We'll have to define reasons for the screening. Right now we don't always practice due diligence because of the other layers in the process that don't understand the protocol. We have tried to communicate to applicants but surveillance makes up only 2-3% of the folks who get an IME.

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

I think it is – this goes back to the first question. We have a healthy Canadian population so in order to keep that we need to communicate and screen.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

For TB, definitely; for syphilis, time has evolved and the decision to have this was made many years ago based on the consequences at the time of untreated syphilis. For admissibility we need proof of treatment but I still see it as part of the screening more for notification (just to nominally tell PTs for epidemiological tracking purposes, but not to impose Ts&Cs). There could be other diseases where we'd like to impose Ts &Cs – we need to talk to our health partners about risks/benefits of this.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

A lot of time it's mental health issues. I'm not sure how stringent the test for that is: how can it determine risk? Anyone can develop a mental health issue at any point. Unless the person has a history of mental illness I'm not sure our test really gets a risk.

Take HIV – it's now accepted as a chronic condition in the medical community so people aren't inadmissible for this condition, but what if the person infects people after arrival because they're not following treatment protocol, and 5-10 years down the road they develop a mental health condition? This could take longer, or could be never, and this could happen to a Canadian citizen too – it's not clear if the assessment of public safety risk is a real determinant for the person.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

The gap I would see is that is seems we have 1 policy but 2 types of applicants. Applicants in Canada aren't recognized as being here already. Visitors for over 6 months could be coming back and forth from endemic countries. Why do we have the time period of 6 months? I wasn't here when that decision was made, and maybe it's an economic thing, but we may need to change our methodology to decide who needs an IME.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

I think it is overall. But then again what I find is there are categories that ED exists for and those it doesn't. So I'm not sure I can comment. For those where it doesn't apply I feel like Canada and the PTs are getting tricked: TRs come to Canada, get sick, and PTs must cover that expense. Maybe this would be detrimental to PTs?

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Because we have no exit control measures, we may want to revisit the 6 months time period. I don't know about development of that line of policy. For follow-up: definitely people who come from those [high incidence] countries regardless of length of stay. IME depending on category, could be adapted: i.e. if you are looking at PR vs student vs visitor maybe do the IME differently (base on status and country of origin).

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

I can't comment as I'm not a part of that section but I know that panel physicians get the manual, training from MOHs , and have standards to follow. We rely on their professionalism as well because they make the decisions.

a) How effective are these tools, training, guidance, etc?

Not asked

b) Are any improvements required?

Not asked

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

In terms of notification it all starts at the visa office because the officer collects all the info so if there are new staff members or they aren't sure of the steps it is detrimental. That's why the manual is online and there is an email inbox for questions.

Follow up question: Is there PT training?

I did some on site in SK, NB, and AB and we have also done teleconference about introducing people to our process.

Claire described the process

Once the officer is ready to issue the visa the medical result will show if the client needs surveillance. When the visa is issued they need to inform the client and issue the medical undertaking form [think this is the IMM 535]. With the new electronic system we see when the information has been forgotten so we have the second layer at the POE to remind/tell clients about the need to report for surveillance if necessary.

a) How effective are these tools, etc?

I noticed recently – for extending permit if they have a condition for surveillance – that Vegreville will not stop an application extension. Instead of telling the client they need to do proof of compliance they just don't address it. This was an OMC decision, I hear. The technology we have has allowed me to see the problems; on the surveillance form we tell the client there may be negative impacts if they don't do their follow-up but then our internal partners/offices don't follow-up. If we tell clients they'll be refused for non-compliance we need to be consistent. I could only see that because Data Warehouse provides information – if anything happens I can counter-verify whether we have received IMM 535. We went for legal advice for the wording and everything but our internal partners don't assist us. Since I started in 2009 I have wanted to go back and follow-up with the non-compliant we know about but our level of resources doesn't allow for this.

We provide guidance on what we mean by compliance. We have templates that we send to the PTs who want them and we have the IPHIS report [need to touch base on acronym] used by Ontario. The PTs get all the tombstone information from us so all they need to provide is a date.

b) Are any improvements required?

If CBSA does not tell us in due time, we can't do our work. This is where improvement is needed. It is an admin task – papers are in the basket so clerks need to just deliver but I don't think this is done every day and if we don't receive these papers we can't notify PTs

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?**

Started to keep stats on communications from PTs around compliance but we just started in the summer. Will see what the Branch can provide [Shawn – maybe follow up with Claire next week?]

Compliance is defined (came from a TB Sub-committee led by PHAC) for immigration purposes as meeting with a health professional for the first time and getting assessed. We do not say when this must happen – maybe we need to look at the definition again to encompass more diseases.

a) **How effective are these mechanisms?**

In BC, AB, SK, QC if in-Canada clients are referred for surveillance they get routed back to the same physician that did IME. [This can cause frustration especially if the physician did not see a reason for surveillance following the IME but the MOH did; physicians see their opinion questioned – MT paraphrasing a very long comment.]

b) **Are there any barriers?**

In terms of communications with PTs it is a bit touchy because the word has different meanings in an immigration context and because it has to do with privacy and confidentiality. Sometimes these are barriers to compliance. Clients are the owners of their information and they should engage their care provider to send the compliance note. Our new consent for says that CIC can ask for information. We have problems with some PTs because they have problems with our methods of transmission – they want to email it but don't like our encryption software.

Also we don't really communicate with visa offices – don't know how or to whom. If we need to send anything we just go through the RMO.

c) **Are any improvements required?**

We try to accommodate whatever format the PT wants to provide compliance as long as either the PHA logo or the CIC logo is on the form (official). It's difficult to see how many comply when PTs provide data inconsistently or not at all. Maybe we could re-visit the idea of putting the responsibility on the client saying that the PHA could provide it to us – currently this is on the IME form but not the medical undertaking form. I would like to get away from the IMM 535 and go electronic because then we would not have to rely on CBSA providing the signed form. It would facilitate our process of notification. There is lots of brainstorming that could happen on this issue.

The differences in application categories – there may be a glitch there. Who do we trust by not asking for compliance in comparison to asylum seekers (basically have a yearly IME unless there is progress on their file). This becomes a double standard, as you are making people report in-Canada more than people applying from overseas. This also happens when a person changes categories; change from visitor to a PR request for example. Without exit control measures it is hard to know how many times in and out or whether person has overstayed.

11. **What changes have been made to the <u>medical screening</u> and <u>notification</u> program as a result of modernization?**

Not asked

a) **What has been the impact of modernization?**

Not asked

b) Have there been any gaps or challenges?

Not asked

12. **Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?**

I think they do – it's a matter of reading information. The handout has been translated to many languages and officers can provide it. The handout explains in plain language why surveillance is required. Not sure to what extent the handout is actually being used – this would be a good question to ask on the survey.

a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?

Language barriers but also fear. The word surveillance can have negative connotations; culturally this can bring up fears of some kind of repercussions.

b) Do you have any suggestions to improve clients' awareness and compliance?

There is a lot of work to be done.

13. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

The instrument ("if this, then this") is too blunt. If the client in –Canada needs to repeat x-ray or provide improvement evidence, they might see the same specialist during the IME and for follow-up. If our RMO says follow-up but PT doctor says no this can be delicate to manage. Why not, if the person has already been seen by a TB specialist, take the information for the epidemiological tracking, but lift the condition?

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

Not for syphilis. For TB it's only for active disease so sometimes people are put on surveillance for nothing. We are investigating the possibility of screening for latent TB. I would strongly advocate this for in-Canada IMEs. Sometimes there is a disconnect between panel physicians and follow-up: it's a glitch in protocol. Everyone is aware of it, but we need to brainstorm on how to avoid bad scenarios.

14. **To what extent has the HSN Program:**

a) Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How do you know this?)*

It would be nice to know if the people we refer develop TB after 1 or 2 years in Canada so we can see if we're doing the right screening. How many took preventative meds? How many developed TB who were not referred for surveillance? It would help to know whether the program makes an impact. This could be shared with the PTs on a non-nominal basis. PT would need to know if residents with active TB were referred (some people don't know whether they were referred or not, or forget). When we are called by PTs to be told that someone has active TB and it was a person who had been referred, I feel we are relevant [and meet these outcomes]. Dr Kamran Khan has done a study on this, which will be interesting to see but it is only using Ontario data, so just one PT, not the whole country.

b) Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this?*

Are there any other benefits of the program to Canada?)

Asked with the above

15. **Have there been any changes to the program that have made operations more efficient?**

There has not been improvement because of technology – we are on a waiting list for GCMS. There are certain rights we don't have – we can't send notification without a signature (but this happens because of CBSA). The communication has been open, the pamphlets and reflect the legal obligation in plain language, which is an improvement. People want to help (partners and stakeholders) but we don't have forums to discuss the issues. Only CCMOH but that's high level – need something more operational.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

PTs have expectations that any issues they raise will be solved quickly but we know that the federal machine doesn't work that way.

b) **Any suggestions to improve program efficiency?**

Not asked

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

To go to electronic notification process and we would like to go that route. My vision is that someone who requires surveillance, as soon as they enter Canada or are issued a visa, the PHLU would receive notification. This would start the process without waiting for a piece of paper (can take days, months from CBSA). It would be cost-effective because we would reduce paper, and reduce courier costs and time. Americans have an electronic system – once an alien enters a state the health unit is notified. Australia does it differently and all the responsibility is with the applicant.

Follow-up question: Are we achieving a good compliance rate?

Truly it's the client's responsibility so I'm not sure if we should have CIC enforcement strategy – these people aren't criminals but if we impose fines, revoke permits, make work permit conditional on compliance, that is a different path.

What about the Citizenship component?

We get a fair amount of questions but the rules are not applied the same way across Canada. For example in AB they'll tell the applicant they'll postpone their citizenship ceremony until compliance is in but in QC they will get their citizenship even without compliance but the Citizenship staff will notify PHLU of the non-compliance.

Do you keep stats?

Not sure – you'll want to talk to a Citizenship Office. When the visa or inland offices give extensions or citizenship without compliance I feel we are useless.

Can a client request their IME results?

It would be an ATIP request. This has always been a wish from partners that clients would arrive with their records. Doctors can ask for files through PHA requests. PHLU can give records to PHA/doctors but not clients. Some PTs request almost all so there' a weekly list. Labour intensive. Right now with e-medical we could send electronically but we don't have a secure method to send it, so we continue to photocopy, transfer x-ray to CD and mail.

INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

2. **a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

   Yes – it is very important because there are many public health related diseases and conditions that can affected Canadians. For e.g. the polio scare in Syria.

   b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Yes – although I am mainly talking about TB. Immigrants tend to reactive (TB) due to the stresses involved in moving to another country. Surveillance means we can catch this before it spreads and creates problems for Canadians.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Yes – it needs to be a federal role. We are aligned with other partner countries in this regard.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

  Yes – we notify the PTs and this needs to be done in order for them to know who is a TB risk in the province.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

N/A

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes – it is still needed because we need to make sure immigrants do not bring any infectious diseases into Canada and put Canadians at risk.

The PH policy in IRPA is outdated and needs to be adjusted to meet the needs of the current environment. Need to review this policy.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

In particular, TB is very important.

We also screen for HIV, but this is not something we put under surveillance, which we should probably consider doing.

Syphilis – we probably do not need to put people under surveillance for this, but it is useful to screen for.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

Yes it is needed and relevant, but it is difficult to assess by PPs and MOs. This policy needs to be reviewed in order to see if there are any improvements to be made.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Yes we are screening for the right conditions, but it difficult to determine if someone is a risk to PS. CBSA will assess migrants at the border if they are acting strangely. This is the last line of defense we have if not caught by the IME.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

Don't know. Not sure the Provinces are that interested in this policy – we have tried to engage them in the past. PTs provide healthcare but they are not interested in helping us make the decisions. Every province has a difference price for treating conditions so we are trying to determine this when MOs are making an assessment. PTs sometimes complain about CICs decision to refuse based on an inadmissible family member.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Yes and No. There are gaps. People who come to Canada for less than 6 months don't need a medical. A lot come from TB endemic populations .

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

Training for e-medical – we offered webinars and training with PPs that went on e-medical.

Training to all staff on GCMS.

PP handbook
MoF handbook
Nurses and case adjudicators have guidance.

a) **How effective are these tools, training, guidance, etc?**

Yes, training and tools were effective.

b) **Are any improvements required?**

Always improvements to be had [offered no example]

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

Not sure. RMO staff have guidelines to report to PHLU.

a) **How effective are these tools, etc?**

N/A

b) **Are any improvements required?**

N/A

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?**

Claire talks to public health.

RMOs communicate with PPs and look after the PP network. Mostly through emails for documentary purposes.

a) **How effective are these mechanisms?**

Generally, yes. Budget has been tight and has limited MO site visits to PPs.

b) **Are there any barriers?**

Receiving the surveillance notifications from CBSA can be slow.

Some PTS don't want to share surveillance info with CIC because of privacy issues.

c) **Are any improvements required?**

Incorporate surveillance notification into GCMS somehow to prevent less paper movement.

11. **What changes have been made to the medical screening and notification program as a result of modernization?**

List: e-meds system, autoclearance in GCMS, panelling radiologists

Updating manuals;

a) **What has been the impact of modernization?**

Shifted the way we work – less manual work and movement of paper files.

b) **Have there been any gaps or challenges?**

Yes. Some system glitches. No problems with auto clearance except IMEs are getting kicked out of autoclearance process that should have been passed.

12. **Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?**

Yes. We have a handout for TB in multiple languages.

a) **What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?**

Not sure all migrants completely understand their responsibility to get surveillance.

b) **Do you have any suggestions to improve clients' awareness and compliance?**

Need to instruct PPs to explain TB to clients so they understand.

13. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

I think this is working well (PH) and identifying TB.

PS: challenges in identifying people.

ED: more difficult to assess in general. Hard to get hospital costing across PTs.

a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

Yes – need better costing info for ED.

14. **To what extent has the HSN Program:**
    a) **Reduced the burden on the health and social services in Canada? Please explain.** ***(Probe: How do you know this?)***

No idea.

b) **Protected the health and safety of Canadians? Please explain.** ***(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

Difficult to determine.

15. **Have there been any changes to the program that have made operations more efficient?**

E meds; autoclearance have made things more efficient. Also, upfront medicals so results are in the system for the VO instead of waiting.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

Some system glitches with e-med and GCMS

b) **Any suggestions to improve program efficiency?**

More upfront medicals.

Better communicate with staff (RMO and visa offices) about changes.

PPs know when a furtherance request is coming, but they aren't always proactive. Maybe have some

guidelines around this to improve efficiency.

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

NA

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE - CPR

1. **Can you please describe how your CPC is involved in the Immigration Medical Examination (IME) and Surveillance Notification Process (i.e. providing the client with surveillance requirement form)?**

CPC-O: Acts like a regular visa office but in Canada. Work on a lot of in-land cases and overseas. They do: FC, Econ Class, FSW, CEC.

TB – required to send provinces a copy of the PFL when dealing with PNP applications and M05 cases.

OSC: deal with inland applications and extensions. Work on visitors, workers and students.

Process: they check if medicals are in the system. If the client requires a medical, they issue a letter requesting the medical.

Medical surveillance required clients: print the forms as required.

CPC-V: process PR applications and some TR. We see the clients' history to see if the client has completed their medical. We also request reassessments to extend medicals.

CPC-M: process FC cases / spousal applications. Applicants submit the forms upfront (the medical is associated with the applicants UCI). For the FC4 (PGP), the role is to make sure the applicant has meds and if not request that the applicant gets the meds. If an m05 case – sometimes the RMO sends this directly to the applicant (occasionally).

2. **What tools, training and guidance are available at your CPC to support the delivery of your role regarding IMEs and surveillance notification?**
    a) **How effective are these tools, etc?**
    b) **Are any improvements required**

CPC-O

The type of training is different than overseas. We don't need training.

OSC

There is a lack of clarity around the role of the RMO and who notifies who (CPC or the RMO?). OSC has internal procedures that we developed. Reassessments procedures are not very clear and have changed over the last few years (i.e. consistency around the amount of time given for us to apply for a re-assessment of an applicant's medical).

CPC-M

There is some information on *connexion*, which is fairly useful. Reassessments can be problematic.

Evaluation of the Health Screening and Notification Program

3. Who do you communicate with regarding medical examination results? How effective is the information exchange?
    a) Are there any standards (i.e., regarding timeliness and accuracy) or mechanisms in place to facilitate the exchange of information?
    b) What would you recommend to improve the exchange of information?

ALL: Mainly communicate with different RMOs and usually through a main email box or through GCMS in terms of reading notes/assessment.

No improvements noted.

4. Is the medical process clear for CPCs? Are there any gaps in the process that can result in people getting "missed" for a medical while inland, either when they extend, change their status, or become PR?
    a) Any suggested improvements?

Overall: no systemic problems that lead to applicants getting missed.

CPC-O: No because they deal mainly with PR.
CPC-M: Medical results that have expired are not on the main screen. This is not always checked. This could possibly be a gap.
OSC: For TR – no gaps in the process.
CPC-V: Occasionally one can get missed, but not a systemic problem.

5. How you know which clients require a medical exam? Are they any challenges in determining this?

Guidelines available. List of countries and categories of whose meds are extended.

6. Is there consistency in processing applications in CPR where medicals are concerned?

In general, yes.

7. Are there any systems issues (i.e. GCMS) or other limitations/challenges in this process?

- The instrument of delegation in GCMS requires managers to assess M05 files; this is not required legally.
- GCMS prevents you from linking the T file with the applications.

8. How do you inform a client that they require medical surveillance?
    a) Are there any gaps or challenges in this process?
    b) Do you have any suggestions to improve clients' awareness?

Sometimes the CPP and sometimes the RMO notifies the client. It was noted that the medical surveillance form is automatically generated. It was noted that this process was not entirely clear and that more clarification was needed.

9. Do you have anything else to add?

Evaluation of the Health Screening and Notification Program

- Overall, the system works well.
- Reissuing medicals and furtherances adds significant time to the application process.
- CPP-O noted that they are tied up in court cases related to M05 (adds time and take a lot of resources)
- Recommendation: The surveillance form could also be emailed to the client when an email exists.

INTERVIEW GUIDE - CIC STAFF – eMedical Staff

1. **Can you describe the function and mandate of the eMedical Unit? What is your role within the eMedical unit?**

Yes, but eMedical is transitioning from project to program – a phased approach.
It is not a formal unit as project transitioning is still taking place. Proposals for eMedical unit components, related to restructuring, have been submitted.

We are tasked with closing out the project and maintaining the IT system, training others – some countries being a priority over others, training panel clinics [includes Panel Physicians and Panel Radiologists and support staff], conducting regular releases, ongoing defect management for program areas.

Role is to support RMOs within eMedical scope and provide answer to questions. Upgrades and updates get done and implemented. We manage CIC components such as release management based on business needs, business roles and business lines.

2. **What was the rationale for developing and implementing the eMedical system (*probe: increasing accuracy, efficiency, integrity, convenience, etc.*)?**

A result of strategic review 2009 – cost saving measures were identified as well as need to modernize health system.
eMedical was a good mechanism to save money and was strategic to meet goals to increase program integrity, improve client services, and service delivery standards.

[Modernization of health system] was identified at FCC meeting, allowed enhancement of partnerships with FCC countries, Australia in particular.

3. **In your opinion, has the eMedical system achieved its intended purpose and goals? What evidence would you point to that demonstrates this achievement? Please explain.**

We are in the process of completing our own evaluation and lessons learned. We had done a PMF for implementation and achieved outcomes and goals.

Achievements would include eMedical being rolled out to Panel Clinics (converted to eMedical) and we know this through established indicators and benchmarks. We are in the process of finalizing evaluation. We could share QA indicators.

We rolled out to 110 countries (109 that are managed by CIC), we look at Panel Clinics, whether they're submitting electronically.

If Panel Clinics did not convert it was typically because of lack of IT infrastructure, internet. In Canada, some hospitals were not able to load the web based system on to their secure system. Panel Physicians were not really given an option to convert or not. A letter went out to all Panel Physicians before the roll

out of eMedical. The Panel Physicians had to confirm and agree to take on eMedical. About 5 said no, and probably because they were months from retirement.

The HelpDesk is managed by Australia (client service managed by Australia's Department of Immigration and Border Protection), they are responsible for meeting service standards.

[Regarding clearance rates] Clearance rates vary by RMO, we are still trying to get clear numbers on this. Must confirm that the system is reporting properly. We rely on GCMS to get data out of eMedical system. We are auto-clearing 70-80%. We did 100% QA during trial and roll out phases. If not auto-cleared, perhaps 25-30% of IMEs, close to 50% of that may be solved through panel member management.

JMa – Asked about impact of auto clearance –

We changed the workflow in RMO Ottawa. We have 3 levels of staff which work on cases that are not autocleared – CR4s, health adjudicators, and Medical officers. Each has its own level of delegated authority. For example CR4s are only qualified to confirm and make assessments on M1s.

[Through modernization] files are now assigned in GCMS which makes things easier – files are easily found with auto-queries and are easily reassigned. File storage has resulted in huge cost savings for CIC.

RMO Ottawa in infancy stages, we are looking at changing service standards. We can look at turnaround time due to dates on files. Can get a decision from Panel Physicians in 5 days, compared to paper format that took 6 months and relied on mail system. Service standards can be examined for whole IME. [Regarding IME] decisions can be rendered and confirmed more quickly.

Due to business rules, we can ensure that files won't be incomplete. There are additional rules that go above the electronic system – e.g. the IMEIs, sometimes they [Panel Physicians] request more information than what is in electronic system. They have the IMEIs and the updated Panel Physician Handbook.

There are improvements to audit functionality, checks get made on any IME submitted (can't submit over 3 incompletes), IMEs submitted follow business rules, rule books are readily accessible. Panel Physicians, while all different, they do respond to going back to training material that is readily available.

4. **What challenges or successes have you encountered which have had an impact on the delivery of the eMedical system? Are there any improvements you would make?**

Originally, we used the eHealth system in Canada, but we created a whole new system. Challenges included working across Departments, with two Governments and two Financial Administration Acts, which made MOUs difficult. Intellectual property laws were different.

[Regarding challenges in implementation] It was challenging due to the short time period, we had 6 months to roll out to 110 countries – aggressive timelines. There were limited resources – both financial and human.

JMa – there are some clinics that still use paper system, any issues?

There were no issues. The way GCMS was built, it allows input of information and GCMS auto-clears. [Regarding challenges] Each RMO managed it differently; we are trying to get at this. We always have to change approach respective to the RMO.

[Regarding Panel Radiologists] There were challenges related to Panel Radiologists with eMedical implementation, designations took place quickly and there are gaps and non compliance as they did not necessarily want to comply with needs. Especially in North America.

Other challenges we are facing, WFA took place right in the middle of the project. We were relocated right in the middle of the program roll out which caused logistical issues. Also the time difference with Australia was challenging.
In November 2012, there was a transition needed for the IME forms – alignment between paper forms and electronic forms and also between Australia and Canada.

We are change fatigued due to right sizing, closing RMOs, changing compliment of ROMs, eMed implementation, growing pains of GCMS... needed more time and more resources.
We submitted transition plans 1.5 years ago and are still waiting on approval. Team is not sustainable, only one indeterminate staff.

5. **What tools, training or guidance are available to support the delivery of the eMedical system?**

We would have liked to do face to face training but not feasible so we looked at training approach. Australia's approach was to provide a CD for Panel Clinics to review, we conducted our training via face to face web based training. We trained more than Australia and we trained all CIC clinics including DIAC-lead countries.

We had an extensive communications plan, with specific matrices, and didn't want to confuse Panel Clinics because they were getting training from both CIC and DIAC.

a) **How effective are these tools, etc?**

[Regarding Training (from CDs)] very few clinics took initiative to do on their own training. Did do clinic integration.

Clarification – CIC sent same materials as Australia (DIAC) but CIC also did a webinar to follow the CD sent to the panel clinics.

b) **Are any improvements required?**

Question not asked

6. **From your perspective, how well has the eMedical system been received by key stakeholders of the HSN Program (i.e., Panel Physicians, RMOs, Visa Officers)?**

I think you will get varied opinions, there is a handful of very resistant RMOs – mostly in Americas... though

they are submitting more electronically now.

Australia and Canada each have a panel network, some overlap. Decisions would be made if there were too many or if redundant in certain areas. - may have more Panel Physicians depending on the network decisions, or matching with Australia's network.

eMedical used as a reason to do things, panel network decreased by 30%. - multiple variables that came into play.

JMa asked how did you determine redundant?

It can be based on numbers, on representation of having male and female doctors, age, and retirement.

RMOs seem very happy, some are resistant, usually with comfort level with IT systems. Management of panel members varied significantly depending on the MOF that was overseeing panel network –MOF had influence on panel member.

Easier to assess electronic file, very supportive overall. There is a diligent communications strategy for RMOs.

OTHER:
JMa asked: why survey Panel Radiologists?

They are integral to Health Screening, they are designated members of the health network, eMedical can't function without them, we get functional responses. They are a new component, which allows us to provide a good baseline. Surveying them should get at relevance of IME, of Program, of process.
We are thinking of designating panel laboratories.

[Panel Radiologists] They have to enter into eMedical, typically they look at the viewer [for films] and dictate their report, then enter the data or they will give to designated support staff to enter data, Radiologists are accountable.

[Regarding IOM] They have been a designated medical practitioner – as Panel Physicians and Panel Radiologists. They have worked as adjudicators on medical assessments; they would be a good entity to survey as well.

Pages 179 to / à 183
are withheld pursuant to section
sont retenues en vertu de l'article

19(1)

of the Access to Information Act
de la Loi sur l'accès à l'information

Pages 184 to / à 187
are withheld pursuant to sections
sont retenues en vertu des articles

13(1)(b), 19(1)

of the Access to Information Act
de la Loi sur l'accès à l'information

Pages 188 to / à 206
are withheld pursuant to section
sont retenues en vertu de l'article

19(1)

of the Access to Information Act
de la Loi sur l'accès à l'information

s.21(1)(b)

INTERVIEW GUIDE –

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification (HSN) Program?**

Did not ask |

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes, right now we have IRPA, A38, so by law we must conduct screening to ensure that we protect public health and public safety and ensure that we are not placing excessive demand. The only way to do this is to assess health before arrival.

Policy on ED mandates that we have to assess ED.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes, this is very important to do for public health reasons to contain the spread of certain diseases. – not just TB but also things like Polio. The challenge is in notification. There is a lot of burden on PTs.

We need to better bridge pre-departure with post departure. This can be done through better surveillance. Right now CBSA sends the notification form to the PT. We are reviewing this process.

3.

a) **In your view, is the federal government's current role in the HSN Program appropriate in terms of:**

- **Facilitating medical examinations and conducting assessments?**

Yes, but we could be doing more (i.e., using the information to focus more on the health of the immigrant).

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Didn't really ask this.

b) **Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?**

Right now we have been questioning the wording of legislations. Medical screening in IRPA is based on 1950s conception of public health conditions. Public health is about communicable diseases, but we public health does not consider admissibility. We are focussing solely on inadmissibility right now and we

need to update the language in our legislation so that we are managing public health based on risk mitigation and keep inadmissibility as the end of the reasons for refusal.

Another issue is that the current leg/mandate doesn't include measures for immunization. We need to fine tune the regulations based on risk-mitigation.

We could be doing more things that benefit the migrant such as promotion efforts and checking their health upon arrival. We do things where the legislation doesn't match/allow; we need to update the regulations to give us a greater/clearer public health mandate.

4.

a) **Is the policy on *danger to public health* still needed and relevant? Why or why not?**

Yes the policy is still needed, but we have lots of questions about just screening for inactive TB and syphilis, so we are reviewing the policy.

b) **Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?**

[Regarding TB and syphilis] these diseases are the ones we screen for but there are others which are just as deadly which we don't screen. Polio, for example in Syria → this is a top priority outside of CIC in the public health field. Maybe we should be looking at similar diseases outside of TB and syphilis

We don't screen for Hep B & C. We have the support of the PTs to look into this but it's not reflected in the current legislation.

At this point, we have had to prioritize the conditions we screen for based on strong epidemiological indicators.

5.

a) **Is the policy on *danger to public safety* still needed and relevant? Why or why not?**

Yes, but we need to define public safety better and move towards a policy of risk mitigation rather than inadmissibility.

b) **Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?**

The policy is usually associated with behaviors such as drug use, mental disorders, etc and these can be difficult to assess. We need to revise the policy to move away from inadmissibility and focus more on risk mitigation. There are people who do well under treatment but we may not let them in because of these conditions.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

It is relevant in the eyes of politicians but again, how do we define this idea? In cases where there would be

ED but PT doesn't care [about the health care costs to their province] (perhaps due to anticipated economic benefits), why should we [CIC] care?

Current regulation is based on the cost and displacement to the health care system. The health care system in Canada is already in trouble. We have a universal health care system, so the policy makes sense. We get many court challenges and they are usually on ED (not on inadmissibility to due public health/safety). Usually this involves the client saying they have a mitigation plan; but due to the nature of our health care system, we cannot bill them anyways.

Where there is a mitigation plan or a PT wants an economic immigrant despite known health conditions, we can't really monitor economic contribution.

We tried in the past to have a FPT table to meet on these issues but it became bilateral in nature because the PTs could not agree on a consultation process. Once an applicant is accepted there is interprovincial mobility so it should be in the best interest of PTs to meet together with federal government.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

I think we screen well for certain PR populations (e.g., refugees). However, the current policy is based on duration of stay (6months) but this doesn't make any sense from a public health perspective; it's a bit arbitrary. We are currently reviewing this policy and are proposing a shift to a more epidemiological focus. TFWs are actually the highest rate group for TB cases. Students are also high.

Medical officers of health in the provinces are asking us to do more screening on students.

8. **What changes have been made to the medical screening and notification program as a result of modernization?**

[asked specifically about *eMedical*]

   a) **What has been the impact of modernization?**

Emed has been working well; overall I am satisfied with it. The system is doing what it's supposed to: auto clearing. It allows for faster processing and allowed us to shift resources. Efficiency has increased. 72-73% are currently being auto-cleared.

[regarding the Panel physician survey]: some PPs are okay with eMeds but some are not. If some PPs continue to be resistant to the change to eMeds, I would be worried because that suggests issues with quality and integrity of the system.

   b) **Have there been any gaps or challenges?**

None indentified.

9. **Have there been any issues, challenges, or successful practices which have had an impact on the management, governance, or delivery of the HSN Program?**

We don't have control over compliance regarding surveillance. This is a difficult issue because we do not have any jurisdiction in this area once the individual has arrived and we do not get information about compliance. We need to have better information sharing with the P/Ts.

eMeds have had a positive effect in meeting business standards. Reports exist on eMed's impact on timeliness. Ask Josée to provide these reports.

We want to have people arriving with their health file (doesn't happen now).

10. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

Not asked

a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

Not asked

11. **To what extent has the HSN Program:**
    a) **Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How do you know this?)***

Overall, despite the need for improvement, we have been doing a good job. Our approach is similar to the Australians. USA used to perform screenings in their own way. This actually contributed to TB rise in that country. USA took the Canadian model and went even further. They are doing vaccinations and risk mitigation.
We do not necessarily know about the impacts. We need to better bridge with PTs.

b) **Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

12. **Have there been any changes to the program that have made operations more efficient?**

We used eMeds to increase efficiency. [regarding additional resource challenges moving forward]: yes there may be additional costs to the applicant. We need to conduct a cost evaluation of new policy proposals. A cost implantation planning is under way.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

b) **Any suggestions to improve program efficiency?**

Nothing noted.

13. **Are there alternative ways of delivering the program that would be more cost-effective and/or**

better achieve the program objectives?

Nothing noted.

INTERVIEW GUIDE –

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification (HSN) Program?**

Visa officers make decisions based on medical results from the MoF. The MoFs report to the IPMs in the mission and officers may consult with MoFs on certain cases (e.g., ED). HB Operations and IR Operations liaise with each other, as needed. For example, IR is consulted by HB on policy changes and was consulted when HB was closing RMOs. There is on formal working relationship, but works well.

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes, given certain population of immigrants and their integration into Canada, we need to do this for public health reasons. Not sure it makes sense to do as part of the visa process though.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

This is difficult to comment on.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Not sure – it is an important role, but not sure it is a CIC issues. Although, guess this is a program integrity issue that we need to address.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Cannot really comment on.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Nothing noted.

4.

a) **Is the policy on *danger to public health* still needed and relevant? Why or why not?**

Yes, this policy is still relevant because it is a public health issue.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

No comments.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

I think it would be hard to assess risk to public safety. And we need to think about whether these conditions may prevent successful economic integration – they do not necessarily.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

Yes, because of the implications on the health care system and to ensure that Canada remains economically competitive. We need the policy because the deterrence effect is very important. However, ED can be hard to assess and the plans that are developed can be very complex. ED cases are the most difficult to assess [speaking based on their experience as FSs].

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Screening makes sense for certain categories, but we have just as much risk from some visitors that aren't screened. For PRs, it makes sense to screen them because they have access to social services so we have a public duty to screen them.

Assume it is done sensible from a policy perspective, however, the timing of the screening might be an issue and things such as 10-year visas may be an issue.

8. **What changes have been made to the medical screening and notification program as a result of modernization?**

[they spoke about e-medical]

a) What has been the impact of modernization?

E-medical has been very successful. We have faster decision-making and more efficient use of resources. We to make some adjustments to operations because of e-medical but there weren't really any issues.

b) Have there been any gaps or challenges?

Nothing noted.

9. **Have there been any issues, challenges, or successful practices which have had an impact on the management, governance, or delivery of the HSN Program?**

No, there aren't really any issues. We have good collaboration with HB and good communications. One question we would have is with respect to the PP network and how HB ensures quality of the IMEs. As we have become more centralized and more automated, this is a potential risk and we need to ensure program integrity.

Governance can also be a challenge for MoFs because they report to the IPMs in the missions, but also to the Director of Operations, HB.

[speaking from FS experience] there may be a need to for visa officers to have more information sometimes. For example we have seen cases that are M5s and then they get changed to M3s and we often do not know why. Due to the nature of the subject matter, we put our faith in the MoFs and their expertise, however, it would be good to have a better understanding in these instances.

10. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

Question not asked.

a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

Question not asked.

11. **To what extent has the HSN Program:**

a) **Reduced the burden on the health and social services in Canada? Please explain.** ***(Probe: How do you know this?)***

Question not asked.

b) **Protected the health and safety of Canadians? Please explain.** ***(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

Question not asked.

12. **Have there been any changes to the program that have made operations more efficient?**

Question not asked.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

Question not asked.

b) Any suggestions to improve program efficiency?

Question not asked.

13. Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?

[Asked about improvements] – Nothing really noted, just that we need to ensure good oversight of PPs to ensure that the basis for the automated process is reliable. Also noted that timeliness can sometimes be an issue, but that is more often related to volume and not issues with the medicals.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

Interviewee conducts IMEs as per the guidelines. Have staff that assist that book appointments, collects and inputs demographic data, and does the basic questions for the IME.

a. How long have you been a Panel Physician for CIC?

b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Conducts about 1,000-1,100 IMEs each year, which constitutes most of his work.

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

A handbook was received in 2009 and following that there were lots of updates provided via e-mail. Received a new handbook in 2012, which included e-medical component. The handbook is fine, but this one is not as easy to go through as it doesn't have a table of contents.

a. Is the information in the manual useful, relevant?

When the handbook was received, it was useful and provided all information necessary. Don't really refer to it very often anymore, unless I come across something I haven't dealt with in a while.

b. Are any improvements required?

Would be nice if the most recent manual had a table of contents.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

These forms are all good, as they are pretty standard in terms of the information we would normally collect. We don't really need to use them that often. I think they are all in e-medical, but I still like to have the hard copy.

a. Are any improvements necessary?

On some of the forms (e.g., assessment of activities of daily living), there are no options to select not applicable. You have to fill out every single box to be able to continue through the form. Having an N/A option would save some time.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

The forms are fine. Most of the information they contain are common sense, but they are good to have.

a. Are any improvements required?

No improvements required.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

We transferred over to e-medical in December of 2012 (used to use e-health). We received lots of training, have the manual, and have had no problems getting information. There is an e-address that we can use to communicate issues about e-medical.

a. How effective were these training and tools?

The training, tools are fine. The e-address isn't that effective in terms of the time it takes to respond. About 1/3 of our requests take 24 hours for a response, but 2/3 take beyond 48 hours.

b. Are any improvements necessary?

No specific suggestions for improvements.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

Implementation was not smooth and there were lots of technical issues, but most of the kinks have now been worked out, although not always very quickly. We do still have some issues. For example, some screens do not have consistent dates and times. Also, we couldn't access the system this morning because of maintenance, which is an issue. The maintenance is not always done at the most convenient times.

7. What impact has e-medical had on:

   a. The way in which you conduct IMEs?

No impact on the way in which an IME is conducted. Just a note that this PP enters the information in e-medical as the IME is done. He suggested that some PPs may do it on paper and then enter it in e-medical following the IME.

   b. The time it takes to conduct an IME?

We aren't collecting as much information, but the time for the IME itself isn't reduced as it takes time to input the information into the system.

   c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

The information that is provided to CIC is now more generic and standard. Fewer details are entered into the system than what was captured on paper. The number of questions that we ask is now reduced and we do not get to know the patient as well. We now only know about major issues. As a family doctor, this isn't how we like to work, but I can see that for the purposes of an IME, just identifying the major issues makes sense.

   d. Other impacts?

There is a bit impact in terms of paper. We now have much less paper to deal with (e.g., storage, less photocopying). E-meds also handles pictures really well.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

We normally communicate by telephone or e-mail. There is very good support from CIC.

   a. Are any improvements necessary?

No improvements noted.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

In terms of risk to public health, yes the conditions (inactive TB, untreated syphilis) are very easy to identify and it is unlikely that we miss anything. In terms of risk to public safety, it can be more difficult to detect these conditions and some things can be missed – likelihood that it is missed is higher than with risk to public health.

a. Are there any gaps in the current approach to conducting IMEs?

The current IMEs are not completed soon enough upon arrival in Canada (note PP in is Canada). We also could be including other diseases in the screening, such as hepatitis and other STDs. We don't need to screen for these diseases for admissibility purposes, but rather to protect public health and ensure treatment is received.

Probed on Excessive Demand to see whether the PP had any comments: *PP didn't really have a lot to say on this except that ED should not be the sole criteria for whether a person is admissible or not.*

INTERVIEW GUIDE – Panel Physicians

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

Identify conditions of TB/Syph/HIV/others of importance. Identify conditions on ED.

   a. How long have you been a Panel Physician for CIC?

   b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

10/week for Canada 20-30 per week in total.

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes; these are thorough. There was a previous version which wasn't as good but the newest version is better.

   a. Is the information in the manual useful, relevant?

Yes – very relevant and useful. I use it when problems arise.

   b. Are any improvements required?

It would be nice to have more information on clinical conditions. More expansion on diabetes, for example – there are multiple interpretations one can take on such illnesses.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

Yes. Works well.

   a. Are any improvements necessary?

None.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

Yes.

a. Are any improvements required?

I would always welcome more information. It would be nice to get feedback on how I'm doing. There are just so many conditions to keep track of. We use the Australian eMedical system to conduct both Canadian and Australian medicals. However, there are subtle differences with Canada. It would be nice to have an idiot's guide to clinical differences between Canada and Australian medical concerns. A handbook may be too cumbersome, but there should be an easily accessible place where this information is contained.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

I receive a lot of information. There was online discussion. I know some doctors have had issues with it but it really is just an issue of getting used to a new system. There were glitches but these have been fixed.

a. How effective were these training and tools?

They were sufficient.

b. Are any improvements necessary?

None.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

I used to use eHealth [which was another Australian system] and the migration to eMed was quick easy for me. I think a system like eMed was inevitable. I find it to be an improvement. There are of course some little IT issues and "quirks" to the system.

I think the inquiry system could be improved. Right now it takes a long time to get a response from DIAC. I email RMO London and they are generally pretty fast with their responses.

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

I've had a positive experience. It has made my work more streamlined. It is faster to submit the IME.

b. The time it takes to conduct an IME?

The actual IME takes about the same time.

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

You are still recording the same information.

d. Other impacts?

None.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

yes

a. Are any improvements necessary?

There is a need for general feedback. Does CIC want more or less detail in the IMEs? What are the conditions and indicators that are borderline? I do receive many emails and bulletins from CIC but would like more feedback on how I'm doing.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

Yes, I think it does a good job. It would be difficult to design more tests. I think Drs are clinically adept enough to ask questions and identify cases of public safety. I suppose it mostly depends on the acumen of the individual physician.

a. Are there any gaps in the current approach to conducting IMEs?

None.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

Conduct IMEs for CIC for PH, PS, and ED reasons. Also conduct IMEs for

   a. How long have you been a Panel Physician for CIC?

   b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

2500 each year.

Procedures and Tools for Panel Physicians

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes it does for most situations.

   a. Is the information in the manual useful, relevant?

Yes it is useful and relevant

   b. Are any improvements required?

The handbook should reflect more information or connect to the e-medical system. Needs more info on e-medical in the handbook.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

Yes – related to the daily living form; if someone has mild arthritis, the PP needs to it out this form even if it is not applicable.

   a. Are any improvements necessary?

For the 'assessment of activities of daily living form', there should be an N/A option, as right now, if it doesn't apply, you have to check every single box.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions

useful and relevant for you?

Yes, useful.

a. Are any improvements required?

N/A

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

Onsite training for e-medical.

a. How effective were these training and tools?

They are ok.

b. Are any improvements necessary?

Could include more information about e-medical in the handbook.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

There were technical issues at first, but not as many issues now.

Uploading x-rays and additional information takes a long time – slows the process. Entering info on paper and then admin staff enters it into e-medical. Still send some forms manually that aren't available in e-medical.

7. What impact has e-medical had on:
   a. The way in which you conduct IMEs?

Much more uniform and faster in some aspects (no courier); however less flexibility since including comments will make the grade fail; the ability to enter comments No space for additional comments. Since e-medical sometimes forces PP to not enter info (mild hypertension / controlled diabetes) because it will become B grade. Sometimes it is hard to just say YES or NO.

b. The time it takes to conduct an IME?

It takes time to enter the information into e-medical. It is entered first on paper and then into emedical. System is slow sometimes.

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

Provide less information now than before. Forces to say YES or NO. Can't add as many comments.

d. Other impacts?

Needed to upgrade computer systems, hire more staff.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Yes, very good. Mainly through email (e.g., monthly newsletter). We contact them as necessary and we get the answers we need.

a. Are any improvements necessary?

Nothing mentioned.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

PH – these conditions are fairly easy to detect.

PS is hard to detect because it depends on what the applicant puts in their history. Relies on people being truthful.

a. Are there any gaps in the current approach to conducting IMEs?

Could include Hep B in the test. It is a public health concern.

Thank you for your time and cooperation.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

    a. How long have you been a Panel Physician for CIC?

    b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

6,000-8,000 per year.

Procedures and Tools for Panel Physicians

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes, very useful and relevant.

    a. Is the information in the manual useful, relevant?

Yes, very useful and relevant.

    b. Are any improvements required?

It should be updated every 2-3 years.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

Forms are good. Simple.

    a. Are any improvements necessary?

Nothing noted.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

Very useful.

    a. Are any improvements required?

Instructions should be upgraded if / when any new information is available.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

Had one conference call on e-medical. This was very different compared to when e-health was implemented. We had on-site assistance for a number of days.

a. How effective were these training and tools?

Training was helpful but would have been good to have more support and on-site training.

b. Are any improvements necessary?

Face to face training by CIC should occur periodically through a conference every so often in different regions.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

Yes, quite a few issues.

- *Administrative: takes 10-15 minutes for each case; medical takes 15-45 minutes; 5-10 minutes debrief.*
- *Server is very slow*
- *Interface is complex and not user friendly*
- *Uploading tests is very slow*

Ultimately the process is good, but it is slow.

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

We do the IME on paper first and then an admin enters the information the next day.

b. The time it takes to conduct an IME?

The whole process is very slow; uploading is slow; takes more time than with paper.

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

No change

d. Other impacts?

We have had to make some investments to be able to use e-meds (e.g., laptop, 5-6 staff).

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Yes, very satisfied.

a. Are any improvements necessary?

The Medical Officers do not meet us as much any more. There was more face to face in the past. Should have a conference in India, every year for training purposes and information updates, etc.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

Yes – very thorough.

a. Are there any gaps in the current approach to conducting IMEs?

We are capturing Polio which is big in India.

Thank you for your time and cooperation.

Risk to public health: The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis. Latent tuberculosis is not considered a risk, as once it is identified it can be treated without risk of infecting the Canadian population

Risk to public safety: The federal government also screens applicants for conditions which may be deemed to pose a danger to public safety. This policy typically considers a variety of mental health conditions such as clinically diagnosed sociopathic disorders, aberrant sexual disorders (e.g., paedophilia), or substance abuse issues leading to antisocial/violent behaviour.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

a. How long have you been a Panel Physician for CIC?

b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Conduct about 20-30 a week.

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

The handbook is good. It provides the guidance for what we need to look at (provides the limits of what we have to do).

a. Is the information in the manual useful, relevant?

Yes, the handbook is good – useful.

b. Are any improvements required?

None noted.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

The forms are fine.

a. Are any improvements necessary?

None.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

Instructions are fine.

a. Are any improvements required?

Small issue – on the assessment of daily living, you have to check off N/A numerous times. It would be good to be able to just have one spot to check N/A – it would save some time.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

We had a seminar (lecture and hands on training) on 2 occasions.

a. How effective were these training and tools?

Training was fine.

b. Are any improvements necessary?

None noted.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

Switching to e-medical was relatively easy, although the system is slow. No major on-going challenges. [has used e-health]

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

No change

b. The time it takes to conduct an IME?

No change to the IME itself. The PP enters the information into e-medical after the exam because the identity portion has to be completed first [the admin staff does this and it can take some time to upload].

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

No change.

d. Other impacts?

The process is quicker and more organized because there is less paper and everything is all in the same place. The paper process was not as efficient.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Don't really communicate directly with the RMO [done via the senior staff].

a. Are any improvements necessary?

Doesn't communicate directly with RMO.

9. **CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?**

PH – yes, we know what to look for and are identifying the TB cases.

PS – we are pretty confident, as we have an in-house psychologist so that we can refer [furtherances].

a. **Are there any gaps in the current approach to conducting IMEs?**

None – think the process is working well – it is pretty optimal at this point.

Other

For DoT treatment, patients have to come everyday for their meds. We report to the RMO with respect to the treatment of active TB cases. We do another IME once the treatment is done.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

Conducts IMEs for CIC.

a. How long have you been a Panel Physician for CIC?

b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Approximately 1000 IMEs per year.

Procedures and Tools for Panel Physicians

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes, I find the Handbook useful. It provides all the needed information; (Dr. Escudero printed the Handbook out – did not appear to have a binded copy);

a. Is the information in the manual useful, relevant?

It would be useful for some physicians. Because I worked directly for CIC from 1991-95, I do not need to refer to the handbook.

b. Are any improvements required?

No improvements noted.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

There are some forms that are unnecessary to complete for everyone. For example, ADL (assisted living) form for people who clearly do not need it. Need to give the PP more discretion for what forms they need to fill out. E.g. Hypertension – need to send the patient to the cardiologist – unnecessary in every case.

a. Are any improvements necessary?

Need to give more discretion to PP regarding what forms to fill out or referrals.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions

useful and relevant for you?

The instructions are useful and good have.

a. Are any improvements required?

Way to assess children is not always correct giving that children from other countries are generally smaller or have different characteristics than North American children.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

Yes, we received training for the implementation of e-meds: webinars (live) and we received CDs with training materials [started using e-meds in March 2013].

a. How effective were these training and tools?

This training was sufficient. The system had some challenges and improvements in the beginning (multiple
s.19(1) *screens that you needed to navigate, now there is only one), but it has improved over time.*

b. Are any improvements necessary?

There are some extra screens/steps that seem unnecessary such as "preparing for grading" step.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

I have heard complaints from colleagues regarding the help being provided by Australia. I have personally had good support from Ottawa. When dealing with Australia, we usually get information back in a few days.

One challenge we've had is with ID documents sometimes not matching the 1442. Sometimes the tombstone data doesn't match in e-medical – my admin needs to correct all of this information in e-medical (address, phone number, etc.), which takes time.

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

noted that he doesn't enter the IME information directly into e-meds; he does the IME on paper first and then enters it into the system. He does this because if he conducted the IME in e-meds with the patient in the office, it would take too long to complete. He noted that it is more work to use the system as there are extra steps involved. It was a simpler process before. The exam itself hasn't really changed. In addition, the admin enters profile info, takes the clients' picture, etc. and enters it into e-meds. Dr E enters the IME info from the paper form to e-medical system after the appointment.

b. The time it takes to conduct an IME?

It takes 40% longer because he doesn't enter the IME information directly into e-meds; he does the IME on paper first and then enters it into the system. He does this because if he conducted the IME in e-meds with

s.19(1)

the patient in the office, it would take too long to complete. In addition, the admin enters profile info, takes the clients' picture, etc. and enters it into e-meds. Dr E enters the IME info from the paper form to e-medical system after the appointment [Dr. E noted that it takes about 8 minutes to enter his assessment information in e-medical, once the basic information has already been entered].

He noted that there is no implication on the client, however.

The benefit is for CIC – not the panel physicians since it takes longer.

c. **The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?**

The medical is the same. Same information provided to the RMO.

d. **Other impacts?**

None mentioned

8. **Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?**

Yes, we receive good support from Ottawa.

a. **Are any improvements necessary?**

None mentioned.

Effectiveness of IMEs

9. **CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?**

TB: Yes – we catch most TB. However, we don't do blood tests for everyone because it is expensive so we do not catch everyone [but are catching most]. We apply a risk-based approach using x-rays.

PS: we catch whatever we can. Depends on the physician. There is no better way to detect risks to PS than by face to face. There is no perfect way to determine if someone is a risk – but we still need the policy.

a. **Are there any gaps in the current approach to conducting IMEs?**

I think we are covering the main ones. TB/Syphilis are contagious and we need to screen for it. HIV needs to be screening for because of the cost, but it is more of a social disease.

Thank you for your time and cooperation.

OTHER:

noted that there seems to be a lack of coordination between the Visa Offices and the medical system.

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The IME instructions tell clients that they need to bring in 4 photos to the PP when they don't need to (this needs to be updated). Clients come in and are angry that they when to the trouble to get pictures taken.

charges money when people ask for their IME results. Does not offer the IME without the client requesting it.

Risk to public health: The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis. Latent tuberculosis is not considered a risk, as once it is identified it can be treated without risk of infecting the Canadian population

Risk to public safety: The federal government also screens applicants for conditions which may be deemed to pose a danger to public safety. This policy typically considers a variety of mental health conditions such as clinically diagnosed sociopathic disorders, aberrant sexual disorders (e.g., paedophilia), or substance abuse issues leading to antisocial/violent behaviour.

INTERVIEW GUIDE – Panel Physicians

Background

1. **Please describe your main responsibilities as they relate to being a Panel Physician for CIC.**

    a. **How long have you been a Panel Physician for CIC?**

    b. **Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?**

Conducted 1,300 in the past year.

2. **CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?**

Yes, I have the 2013 handbook. I have it printed out and also have access on-line. Yes the information is good.

    a. **Is the information in the manual useful, relevant?**

The manual is very good and provides all of the information necessary. Would consult with head administrator or our TB specialist if necessary.

    b. **Are any improvements required?**

No – it is fine.

3. **There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?**

The forms are fine.

    a. **Are any improvements necessary?**

None.

4. **CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?**

The instructions are fine – provide what is needed.

a. Are any improvements required?

None

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

We had a quick overview one afternoon from the person in the office that attended the Paris training. But I mostly learned by doing. There is also a guide that we can refer to.

a. How effective were these training and tools?

Training and tools were fine.

b. Are any improvements necessary?

None noted.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

The transition to e-medical was very difficult. The system was very slow at first. Ideally, you should be able to enter the information directly into e-medical as the IME is done, but you cannot. So we do it on paper and enter later [the registration information has to be completed before the PP can enter the information into e-medical and that can take time].

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

No change

b. The time it takes to conduct an IME?

No change to the IME itself, but the system can be slow when entering the information.

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

No change.

d. Other impacts?

The submission process is faster and more convenient (i.e., no paper to mail).

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Yes, we know the right channels of whom to contact. There is good support.

a. Are any improvements necessary?

None

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

For PH – yes, it is a good tool. Our TB protocol is very strict to it is very hard to miss someone.

PS – this can be more difficult to know – hard to elicit mental health issues and history.

a. Are there any gaps in the current approach to conducting IMEs?

Overall, IME process is good. One gap might be with vaccinations [should be checking what people are vaccinated for and then administer as necessary].

Other

We get a lot of complaints about the consent form because the printing is very small – some cannot read it very well.

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INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

   a. How long have you been a Panel Physician for CIC?

   b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Conducted 1392 last year

Procedures and Tools for Panel Physicians

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes, useful. It tells us what the important information is and what not to look at.

   a. Is the information in the manual useful, relevant?

Yes, the manual is good.

   b. Are any improvements required?

None noted.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

The forms are good.

   a. Are any improvements necessary?

None noted.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

Everything is fine – no issues at all.

   a. Are any improvements required?

None mentioned.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

We were already trained on e-health so e-meds it the same, no extra training required.

a. How effective were these training and tools?

Didn't have e-med specific training.

b. Are any improvements necessary?

For e-health, there is a PP gateway, where you can post questions or get information. Normally a response is received within 24 hours. But this is not available for e-medical. This would be useful.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

There were some challenges at first (e.g., we couldn't upload the furtherances) but everything is working ok now.

But the system can be slow or stops working sometimes.

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

The IME itself is no different. We do the IME on paper first and then an admin enters the information the next day.

b. The time it takes to conduct an IME?

No change

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

No change.

d. Other impacts?

We now have less staff because we have less paper to manage.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Yes, very satisfied. You can contact the RMO anytime.

a. Are any improvements necessary?

N/A

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

PH – good tool for TB, it is easy to detect.

PS – can be more difficult to detect – this is why we ask for all of the patient's history and medication that they are on.

a. Are there any gaps in the current approach to conducting IMEs?

Nothing noted.

Thank you for your time and cooperation.

IME Process

- *We check the ID of the patient and take a photograph (digital)*
- *The IME is conducted*
- *The blood work and xrays are all done on-site.*
- *The passport is checked at every stage*
- *All information is uploaded into e-meds as it is received.*

Risk to public health: The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis. Latent tuberculosis is not considered a risk, as once it is identified it can be treated without risk of infecting the Canadian population

Risk to public safety: The federal government also screens applicants for conditions which may be deemed to pose a danger to public safety. This policy typically considers a variety of mental health conditions such as clinically diagnosed sociopathic disorders, aberrant sexual disorders (e.g., paedophilia), or substance abuse issues leading to antisocial/violent behaviour.

INTERVIEW GUIDE – Panel Physicians

1. **Please describe your main responsibilities as they relate to being a Panel Physician for CIC.**

   a. **How long have you been a Panel Physician for CIC?**

   b. **Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?**

Not sure how many for Canada exclusively.

2. **CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?**

Yes. They are generally informative and useful. We notice little updates here and there which is useful and appreciated.

   a. **Is the information in the manual useful, relevant?**

Yes, we use it regularly.

   b. **Are any improvements required?**

More information is always welcome. [No specifics given].

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

Yes.

   a. Are any improvements necessary?

No issues.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

We receive IMEI messages which contain important instructions. These are useful.

   a. Are any improvements required?

No issues.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

I think there was a webinar. There was a conference with FCC countries which had Canadian staff instruct us on eMeds. There was also CD.

a. How effective were these training and tools?

Fairly effective.

b. Are any improvements necessary?

None at this time.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

Challenges - There have been many changes over the years to how we must conduct IMEs. Compared to previous systems, we find the eMed system to be slow. There are many loading issues (i.e., lag) which we have checked into and they are not the result of systems or connections on our end – so it must be a connection/server issue elsewhere. The system itself requires a lot of clicks of many boxes to tick.

There are also technical design issues which can be frustrating. For example, if you go through the IME and you missed a box in an earlier section, the system doesn't flag these until you hit submit at the end. By that time, the patient may be half way out the door. There should be a flag at the end of each page to indicate if there is something missing. The system also doesn't show all missing fields at once. It shows missing fields one at a time, which can be quite frustrating.

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

Not much change.

b. The time it takes to conduct an IME?

Has made the examination somewhat longer due to page loading issues, bugs, and poor design. In terms of furtherances, CIC doctors used to be able to tell us right away whether to do additional tests, now it takes longer.

c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

There is actually more paperwork associated with eMeds. Although it's an online system, blood results (for example) are still done by paper. There's quite a bit of work. A lot of time is spent on the phone figuring out the system with DIAC.

d. Other impacts?

None.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Generally yes – however, direct contact is welcome. We have never met with anyone at CIC face to face (except for this evaluation). It would be nice to hear from CIC time to time on how we're doing.

a. Are any improvements necessary?

Perhaps there should be a flow chart of who to contact regarding various issues. We are not quite sure who to call regarding issues. Sometimes we are told to contact CIC in Ottawa regarding eMedical issues but we also heard this is only for French speakers. It is not quite clear. In the past there was a lot more direct contact with Canada and it was much easier to make inquiries.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

Yes, medical tests are good. It is fairly straight forward.

a. Are there any gaps in the current approach to conducting IMEs?

None that we can think of.

OTHER ISSUES:

There are sometimes issues with the MyCIC online application submission system. The system tells some applicants that they need a medical so they come in and we know that they actually don't need one. So there's some confusion there.

Applicants are also not aware that we take their digital pictures on site at the time of the IME. Some applicants come to the exam with their own photos because they read that they need this (perhaps online instructions need to make this clearer) but we can't use these photos.

The IME consent form is still done first on paper and then scanned and uploaded. This is time consuming and laborious. CIC should look at simplifying this process.

INTERVIEW GUIDE – Panel Physicians

Background

1. **Please describe your main responsibilities as they relate to being a Panel Physician for CIC.**

    a. **How long have you been a Panel Physician for CIC?**

    b. **Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?**

Conduct about 20-30 a week.

2. **CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?**

Yes, the handbook is good – useful.

    a. **Is the information in the manual useful, relevant?**

Yes, the handbook is good – useful.

    b. **Are any improvements required?**

No – it is fine.

3. **There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?**

The forms are fine.

    a. **Are any improvements necessary?**

None.

4. **CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?**

Instructions are fine.

    a. Are any improvements required?

It would be good to have more information on how to assess mental health issues. There is currently no direction on how extensively to screen for these conditions or guidelines on when to refer people.

5. **CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?**

Had a webinar in 2012 and there is also a user guide.

   a. **How effective were these training and tools?**

Webinar was useful. The transition to e-medical was not difficult because I was already trained on e-health.

   b. **Are any improvements necessary?**

None noted.

6. **Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?**

The transition to e-medical was not difficult because was already using e-health.

7. **What impact has e-medical had on:**
   a. **The way in which you conduct IMEs?**

No change

   b. **The time it takes to conduct an IME?**

No change to the IME itself. The information is entered into e-medical after the exam because the identity portion has to be completed first [by admin staff].

   c. **The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?**

No change.

   d. **Other impacts?**

The submission process for normal cases is faster and it is easier to correct any issues / errors.

8. **Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?**

We communicate with Dr. Rasalan [RMO LES-MD] as needed. There is good support provided.

   a. **Are any improvements necessary?**

None noted

9. **CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that**

would pose a risk to public health or safety?

PH – the process works well in this case.

PS – can be difficult to assess because of the lack of guidelines for mental health [this PP site has its own mental health tool for the PPs to use].

a. Are there any gaps in the current approach to conducting IMEs?

None.

Other

We oversee the TB treatment [have DoT treatment available at this PP site]. We see the patient at 2, 3, 4 and 6 months and do a full reassessment once treatment is done. We report to the RMO after the treatment is completed (or if the RMO requests an update during the treatment phase).

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INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

Interview patients and conduct IME.

a. How long have you been a Panel Physician for CIC?

b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Approx. 30-40/month = 360-480/year

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes, the handbook is clear and provides the necessary information. The most recent handbook is much better than the one from 2009. I found the 2009 version less organized and harder to use. That handbook was just a binder and the language in that version seemed rude and condescending. But the new one is much clearer and more concise, as well as being helpful (i.e., I use it once in a while and have found it useful). The tone of language has been improved.

a. Is the information in the manual useful, relevant?

Yes.

b. Are any improvements required?

No.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

The forms are not easy to use. For example, the boxes don't seem to be in the right places. Another example: the MNSI exam results (i.e., the cognitive assessment for individuals over 65yrs requiring them to draw a picture) have to be scanned. This scanning process is not always easy and it's also very time consuming now because in the past, we would just send this in the mail.

a. Are any improvements necessary?

Find an electronic method for conducting portions of the exam requiring the patient's input (i.e. the MNSI exam).

4. **CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?**

Yes, they are useful and relevant. There may be some grey zones but I can't think of any issues right now.

a. Are any improvements required?

Not sure.

5. **CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?**

We received some instructions on how to upload Chest x-rays; a CD training kit; and teleconference sessions with other clinics and CIC.

a. **How effective were these training and tools?**

These were inadequate and did not address persistent questions and issues. CIC is also rarely available to provide guidance and when we do receive a reply, it's 10 days after we sent it.

b. **Are any improvements necessary?**

Quicker and better guidance is needed from CIC when PPs have technical questions regarding eMedicals.

6. **Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?**

Yes, many challenges. I've been using the system since March 2013. Beyond the lack of necessary training, the system was just so foreign to us. The system is not intuitive at all. There was a steep learning curve. It has gotten marginally better over time, as we've adjusted, but there are still dead ends, slow connections/loading, and creates many frustrations in our work.

We felt like nobody gave us any help and we were just forced into a bad, poorly designed, and primitive system.

For example, the server is hosted in Australia, but we are in Canada. This creates a long distance for the information to travel and makes the system quite slow.

I don't work in the eMedical system during the IME. I write everything down using paper forms because it is simply faster this way and more efficient. I then get another staff member to type these into the system. I needed to hire an additional staff member just to help with this inputting and I have had to pass on these costs to the patients (i.e., $100 more per patient than before). I have seriously considered dropping the whole [eMedical] system.

7. **What impact has e-medical had on:**
   a. **The way in which you conduct IMEs?**

I still use paper because it is easier than using the system during an IME. I have another staff member input the data after the fact.

b. **The time it takes to conduct an IME?**

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It takes longer using the eMed system. There are many bugs in the system.

c. **The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?**

The information is basically the same.

d. **Other impacts?**

I would guess that it has had a positive effect on the amount of paperwork CIC deals with and it is more secure. But this system is not helping PPs; it is hindering us. I have colleagues that feel the same way.

8. **Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?**

We used to have great rapport with CIC employees [prior to eMedicals]. It was easy to call them up and ask them questions. But they've all been let go. It's much more time consuming now for us because CIC has essentially dumped the inputting work onto us. It cuts their costs at our expense. This wouldn't be so bad if CIC was there to provide timely guidance, but this is not the case. I wait for 10 days to get answers from CIC regarding technical (e.g. why I can't load the system, how to use the system) and screening (e.g., what to do about certain patients or medical questions) issues. In the past, it would take 2-3 hours to get a response.

a. **Are any improvements necessary?**

Faster response from CIC to PP questions.

9. **CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?**

Yes, the IME is fulfilling its purpose in terms of conditions that pose a public health concern. We have very good detection for TB, Syphilis and HIV cases. These are the right conditions to look for because these are conditions that can go unnoticed but be very serious if untreated and spread. Finding these conditions early is, therefore, beneficial. There are other conditions like Hep B and C but I don't think these are as big of a concern. Hep C is mandated already through other tests. It's also not as easy to catch. Hep B carriers are often from Asia and South America, but this has vaccines. Incidence of Polio is low and most Canadians are immunized against it.

In terms of public safety, patients are asked questions to get a sense of their backgrounds, which could lead to more questions. There's no formal training on doing this.

a. **Are there any gaps in the current approach to conducting IMEs?**

In I haven't received training on how to assess excessive demand. I've dealt with many conditions like PTSD, people who have survived assassination attempts, refugees, etc and I have no training on these conditions. Of course I do my own reading but there are no resources provided by CIC. It would be nice to have more training in terms of public safety conditions and Excessive demand.

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INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

a. How long have you been a Panel Physician for CIC?

Interviewee is not a PP, His responsibilities include reviewing cases, as needed; responding to questions from PPs; overseeing the operations of the facility. Have regular meetings [weekly] with the PPs and supervisors to ensure consistency.

We started on paper medicals, but switched over to e-meds 1 month after opening.

b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

The facility does 200-300 IMEs per week.

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

All CIC tools are very useful – we use them all of the time (all countries have different requirements, so it is important to have this guidance).

a. Is the information in the manual useful, relevant?

Yes – the tools is very good.

b. Are any improvements required?

No – it is fine.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

All CIC tools are very useful – we use them all of the time (all countries have different requirements, so it is important to have this guidance).

a. Are any improvements necessary?

None.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

All CIC tools are very useful – we use them all of the time (all countries have different requirements, so it is important to have this guidance).

a. Are any improvements required?

None

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

We had staff go to Paris for the training and then those staff provided an overview to the rest of the staff. We created scenarios for people to work on to get practical experience. There is also an electronic manual.

a. How effective were these training and tools?

Training and tools are fine.

b. Are any improvements necessary?

It would have been good to have on-site training.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

Switching over to e-medical was a very difficult learning curve. We had a 1 month transition period. The system is very slow, although it is getting better. There are a number of challenges with e-medical:

- *There is no reporting function for us in e-meds, so we are currently doing double data entry (i.e., once into e-meds and then again into our IOM system). We have reporting requirements to IOM and thus need to ensure we have good record-keeping (e-medical is insufficient for this). It would be good if e-medical could be more integrated with the IOM system.*
- *We have to take a digital photo and then upload it to e-medical. With the UK clients, we can take the photo from a webcam, so then don't have to upload it – this reduces the chance of error [for UK clients, the IOM uses its own database].*
- *The consent forms are printed too small – people complain about this.*
- *It can be hard to organize the flow of patients because there is a certain order in which things have to happen (i.e., administrative portion, IME, tests, finalization). Because of the system, we have no flexibility in this process.*
- *We would like to enter everything into e-medical at the time of the exam, but we cannot always do this (e.g., administrative data can take time to upload, cannot finalize a case until we have the test results, which usual take one day).*
- *Also, we cannot edit administrative data [names on client passports do not always match the administrative data in e-medical].*

7. What impact has e-medical had on:

a. The way in which you conduct IMEs?

Not discussed

b. The time it takes to conduct an IME?

Not discussed

c. **The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?**

Not discussed

d. **Other impacts?**

Not discussed.

8. **Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?**

We have very good support from the RMO – they are available all of the time and we talk to them often. They have done site visits to this facility. I would communicate with the MoFs, the PPs may communicate with the MoFs, and our registration desk would communicate with the PA (Manette).

a. **Are any improvements necessary?**

No improvements – we feel very comfortable that we can call them.

9. **CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a risk to public health or a risk to public safety (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?**

For PH – we have high rates of TB and therefore have a very strict TB program [as per IOM standards]. Very confident in this aspect.

For PS – this can be a challenge to detect – need to ensure that we are allocating enough time with the patient to be able to detect these conditions.

a. **Are there any gaps in the current approach to conducting IMEs?**

Nothing noted.

Other

For the active TB cases, we send them to a pulmonologist for treatment. We stay in touch with them during treatment and then the PP has to see them again following treatment.

We would like to be doing more work to provide field intelligence to CIC. We have a lot of knowledge about TB in this area and we could be providing some useful information.

INTERVIEW GUIDE – Panel Physicians

Background

1. Please describe your main responsibilities as they relate to being a Panel Physician for CIC.

   a. How long have you been a Panel Physician for CIC?

   b. Approximately how many immigration medical examinations (IMEs) do you conduct on behalf of CIC each year?

Do about 30 IMEs per week.

Procedures and Tools for Panel Physicians

2. CIC's *Panel Members Handbook* contains guidelines, procedures, roles, responsibilities and service standards for Panel Physicians. Does this manual clearly provide you with the information that you need to understand and carry-out your responsibilities as a Panel Physician?

Yes, useful because it tells us what the important information is and what not to look at during the exam.

   a. Is the information in the manual useful, relevant?

Yes, useful. It tells us what the important information is and what not to look at.

   b. Are any improvements required?

We want regular updates of this information to tell us what is relevant and not. When any changes are made – need to update.

3. There are a number of forms that CIC has developed for Panel Physicians to use during the conduct of the IME (e.g., medical report, specialist's referral form, chart of early childhood development). Are there any issues with respect to these forms in terms of what information they capture and their utility for you in completing the IME?

The forms are fine. Now with e-medical, they are all in the system so easy to use.

   a. Are any improvements necessary?

Think it would be useful to allow PPs to provide additional information during the assessment, such as "what are the chances that they will need to be hospitalized in the next 5 years" , etc.

4. CIC also issues medical instructions for Panel Physicians, which contain guidelines on assessing or screening various conditions (e.g., cancer, HIV, developmental delays, etc). Are these instructions useful and relevant for you?

Yes, they are all good. For odd circumstances we call RMO Delhi.

   a. Are any improvements required?

Nothing noted.

5. CIC recently implemented e-medical across its network of Panel Physicians. What training and/or tools were made available to you with respect to the implementation or use of e-medical?

Had training on the Australian system (e-health). [didn't mention anything else in terms of training or tools].

   a. How effective were these training and tools?

Didn't mention specific training for e-meds.

   b. Are any improvements necessary?

Didn't mention specific training for e-meds.

6. Did you experience any challenges in implementing e-medical or are there any ongoing challenges in using it?

The system is very slow and uploading information can take a long time. Every time upgrades are done, there are additional bugs.

7. What impact has e-medical had on:

   a. The way in which you conduct IMEs?

No change

   b. The time it takes to conduct an IME?

No change [the paper forms are still used and then the information is entered later].

   c. The information that is provided to the CIC Regional Medical Offices (*probe for whether the information provided is now different that previously, the impact on consistency*)?

No change

   d. Other impacts?

The biggest advantage is that there is a lower chance for mistakes on the part of the PP because the system doesn't let you enter anything incorrectly. Also, it eliminates the physical transmission of the files which means better security of the files.

8. Overall, are you satisfied with the level of support and communication from CIC with respect to your responsibilities as a Panel Physician?

Yes, very satisfied, if we have any questions, we can contact the RMO. There is a huge benefit in having that office in the same city. They come and visit this clinic – all is very good with the RMO.

   a. Are any improvements necessary?

Nothing noted.

Effectiveness of IMEs

9. CIC's policy with respect to health screening involves assessing individuals to determine whether they would pose a **risk to public health** or a **risk to public safety** (see below for definitions). Do you think that the current IME allows for the accurate identification of diseases or conditions that would pose a risk to public health or safety?

For PH – it is very easy to identify TB.

For PS – it can be missed, but not sure if there is a better way to screen for this.

a. Are there any gaps in the current approach to conducting IMEs?

Nothing noted.

Thank you for your time and cooperation.

Risk to public health: The federal government currently screens applicants for medical conditions which are deemed to be a danger to public health. These conditions include active tuberculosis and untreated syphilis. Latent tuberculosis is not considered a risk, as once it is identified it can be treated without risk of infecting the Canadian population

Risk to public safety: The federal government also screens applicants for conditions which may be deemed to pose a danger to public safety. This policy typically considers a variety of mental health conditions such as clinically diagnosed sociopathic disorders, aberrant sexual disorders (e.g., paedophilia), or substance abuse issues leading to antisocial/violent behaviour.

INTERVIEW GUIDE - CIC Senior Managers - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification (HSN) Program?**

Did not ask

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes – There has been rising emphasis on immigration. Over the past 10-15 years, immigration source countries have shifted. Looking at the top 10 source countries, they all contain high incidences of diseases of public health significance to Canada. Therefore, screening is needed to mitigate this risk.

The various policies on screening – such as ED - also act as a disincentive on applicants who might come here just to use the health care system. In terms of screening for public safety, this is difficult to assess. I think we still need to do it but whether it's making a difference, I do not know, since it's mostly self-reported.[sp1]

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes – It is important to ensure that we link people that have health risks. If we want to embrace a risk-based approach to screening, surveillance will become even more important.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**
- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

No - We have the constitutional mandate to do more than just admissibility, though we don't currently have the legal authority. We should be doing more. That is why we are moving forward with a new plan to change the program, which incorporates 4 areas of development:

1) *Greater authority on pre-departure: involving more health intervention at refugee camps (e.g. treatment, pre-departure health, medical assistance, etc.)*
2) *Risk-based approach to IMEs: involving differential medical examinations depending on the world region. This approach would be dependent on an assessment of the epidemiological risks involved in different areas. Therefore, more screening may be required in certain places and different conditions would be screened depending on the region; so the IME would be different in different places. This will require more active review of health indicators and updates depending on conditions.*

3) *Knowledge transfer and information-sharing: we currently can't get data on trends from the PTs and PHAC. We need better aggregate data sharing among stakeholders so as to better protect the health of Canadians. This movement will require more follow-ups from the federal government. eMeds may help but there are resource implications.*
4) *Surveillance and compliance: Surveillance doesn't work as well as it should. We're dependent in many ways on CBSA and on the PTs, but CBSA doesn't always follow up with us and the PTs don't send back affirmations. We need to know about compliance b/c it has an effect on the citizenship process. We have never revoked a visa or citizenship due to non-compliance.*

There has been general agreement from OPS that these policy changes are moving the Program in the right direction.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Did not ask[sp2]

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes - in terms of the notion of screening for public health issues; it is needed. However, I have a problem with the term "danger" to public health. This word (danger) should be changed to "significant" to public health. The word danger suggests a sense of immanence, but a lot could happen between the time of the examination and arrival.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

We're not entirely screening for the right conditions. There are gaps -we apply a limited definition that is related only to infection disease. We should be able to do more in terms of identifying latent TB. We should be able to do more in terms of screening the entire family of applicants. We should be screening for HEP B and C, and Gonorrhea, especially the multi-drug resistant strains of this disease.

We should be allowed to screen for other chronic diseases as well. For example, there is a high prevalence of diabetes in the Philippines. We should be providing this evidence to help PHAC identify public health campaigns for these populations. We should be sharing more information with our partners.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

Yes, still needed and relevant because if we had even one bad case get through and something happened, you can be sure people will ask why we let this person in [therefore, implied high political risk]. We don't really find many [PS] cases – I think only about 75 cases in 10 years. Most of these cases are from within Canada where we can obtain psychological reports. It is much harder to know whether a person will be a danger to public safety [than public health], but I suspect that the policy will not change.

We're trying to develop better risk assessment tools for doctors. The policy is in place to catch the most obvious cases.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Yes - generally it seems like we are. Most other countries do not have this policy; I can only think of one other country that does it. We have also never had any litigation on Public Safety decisions and it's never been flagged as an issue by the OAG.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

Yes, it's still needed. It acts as deterrence on those with excessive demand conditions from applying; if only just for this reason, it is needed. But whether we are assessing it in the right way, I would be inclined to say no. Instead of looking at costs, we should also be looking at the social and economic contributions that the applicant may bring to Canada. We may be accused of discrimination based on economic/socio-economic status but I think how we assess ED should be revisited.

[Regarding making mitigation plans more stringently monitored/applied] – The Australians use a "social bond" which is essentially money paid upfront by the applicant and held on the condition that they abide by the mitigation conditions they have agreed to. If they do not abide by their conditions, the money may be used by the government to offset their costs. In Canada, this kind of approach would be difficult to implement considering PTs are the ones who bear the cost of health care, so a federal bond would not go towards the PTs. Even if there was a pan-Canadian approach with fed-prov agreements to transfer money to the PTs, the mobility of migrants once in the country would make it difficult for that money to follow them to whichever province they move.

This is why I think considering economic contributions/impact is a better approach since this is linked to the client no matter where they go. We also need follow-ups on mitigation plans and better enforcement. Information-sharing is a key issue for us because once someone arrives in Canada they are out of federal jurisdiction. At the same time, the PTs don't give us information on their residents.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

No – when you look at issues brought up by the PTs, the people who they catch with conditions are mostly TFWs who were exempted from an IME; they are also unscreened students. If we put in place a risk-based approach, it will greatly change not only what is screened but also who is screened.

We have heard anecdotal evidence that in some schools, [unexamined] foreign students have transmitted serious illnesses such as mumps to others. We need to link the Study Visa to the IME so that we can review the impact of this population. We also need to review the 6 month threshold for IMEs. I've heard that this policy may not make sense, though we may need to keep it because it becomes unfeasible to apply IMEs to everyone – there needs to be some kind of cut-off, whether 6 months or otherwise.

Another gap is those who enter on multi-entry visas, who should be actively screened. These people may come into Canada healthy, but they are returning (perhaps) frequently to a high risk country. We are also dying to see entry-exit conditions applied. Of course the problem with such changes is that it creates

additional burdens on the client and on client services. Therefore, we need to think strategically about this issue.

8. **What changes have been made to the medical screening and notification program as a result of modernization?**

Modernization changes: design and implementation of eMedicals, downsizing RMOs [i.e. Centralization].

a) What has been the impact of modernization?

I have not been involved with [eMedicals]. Some people believe it is a great tool while others don't think it works well. So there are mixed feelings. Like any system, there were problems and bugs in the beginning. There was some troubleshooting involved but these may have normalized. I have heard staff have had to adapt their operations on the go and I think the system still has yet to demonstrate that it fully meets the intended outcomes [of both efficiency AND effectiveness].

There has been an impact on the QA processes because of e-meds. There just hasn't been enough resources to implement QA.

There certainly has been a positive impact on efficiency and timeliness, but the system still requires a lot of management. Also, the cost is always an issue because we have to pay for it. There has been work to streamline and harmonize processes and leverage partnerships.

[In regards to downsizing] I think this has been linked to the adoption of eMedicals and stem from the strategic review. Senior management felt there was not as much need to have so many RMOs around the world.

b) Have there been any gaps or challenges?

eMeds [and modernization] have not had an impact on the notification aspect of the program. I know that HB is in negotiations to implement an electronic notification system but this is still in the discussion phase and is a long way off. We need to modernize and standardize the notification process.

9. **Have there been any issues, challenges, or successful practices which have had an impact on the management, governance, or delivery of the HSN Program?**

[In terms of challenges on notification] it is difficult to obtain compliance and get the necessary information from CBSA and the PTs. In this program, we rely on many people outside of CIC. Do employees in other departments and organizations receive the adequate training? Do they care? I think these are questions I would be interested in knowing.

We need to create better linkages between the pre and post arrival stages of clients. We need to do a better job of flagging and referring more diseases to the PTs. We should be doing more intelligence gathering and communication/info-sharing with the PTs on more conditions in various countries. For example, some countries have good mass immunization programs, but there are some citizens who are older and who haven't been immunized. These [nuances] should be explored and identified. Canada's public health authority does not do any of this; PHAC has a more domestic health role. PHAC really sees

CIC as the one who should develop policy on international migration health. PHAC runs the GPHIN Program, which is a global health alert system, but they don't do much with this information. They ask CIC what we are doing about certain groups of people in terms of entry restrictions.

10. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

Mostly effective - The PPs are mostly up to Canadian standards. We don't get any challenges on how the IME is done. Court challenges are usually about procedural fairness. I think the question to ask is more about whether we are doing the right IME [i.e., our IME process does a good job identifying TB/Syph/HIV, but maybe our IME should include more than just these diseases].

   a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

[Already explained policy gaps] Otherwise, operationally not really... maybe the electronic processing [eMeds] could work better.

11. **To what extent has the HSN Program:**
   a) **Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How do you know this?)***

Not sure - We don't have comprehensive data on results. There is no confirmation from the PTs [as to Program results]. What we do know - which has been well researched - is the "Healthy Immigrant Effect". That is, immigrants as a group, arrive healthier on average than Canadian-born people, though this effect diminishes with the length of time spent in Canada. This effect may be partly due to our screening procedures and a product of the self-selection of applicants.

We also know the dollar value of all TB cases found and, therefore, the cost savings on Canada; what we don't have is a systematic way of analysis. We need to do more systematic analysis of these issues.

   b) **Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

I have already talked about this and have nothing more to add.

12. **Have there been any changes to the program that have made operations more efficient?**

[Question amalgamated with 13]

   a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

   b) **Any suggestions to improve program efficiency?**

13. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

There are policy and legal limitations. Legally, we can't do any more. This may have an impact on efficiency. There are also resource implications. We may not have the right resources for the work that we do now.

INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

When interviewee focussed a lot of IFH, but also was responsible for researching and developing options for defining danger to public safety. Also did some engagement with P/Ts on health issues (e.g., public health notification, excessive demand). Also used to write briefing notes on different topics.

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes we need to be doing this from a legislative perspective. But also this is important from a public health perspective to protect the public from risks.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes, we need to be notifying the provinces of these cases to ensure that they are linked to the health network. But I don't think we have a role in monitoring compliance, as that is a P/T responsibility.

3.

a) **In your view, is the federal government's current role in the HSN Program appropriate in terms of:**

- **Facilitating medical examinations and conducting assessments?**

See b

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

See b

b) **Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?**

I think CIC could be doing more on the integration side in terms of helping individuals understand their health conditions, and health care. It would be beneficial for them to get information on their conditions and then link them to the services that are available. This is particularly important for refugees, as they can have complex health needs and little experience with our health care system.

4.

a) **Is the policy on *danger to public health* still needed and relevant? Why or why not?**

To the extent that a disease would pose a risk it makes sense to screen from an admissibility perspective. There are some conditions, such as TB that can reactivate – TB is highly contagious and very costly.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

No comment on this – will assume the experts have it right.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

This policy is less clear than the others. It is good to be doing a policy review because we haven't looked at this in a long time. When at HB, I was trying to define what was meant by 'danger to public safety' and there really isn't a lot of information or history on what we mean by it. There is a lack of consensus amongst the MoFs on this definition. We need to review how feasible it is to actually detect these conditions in screening, particularly in the context of how we currently screen.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

No comment.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

This is much more of an economic issue and really an issue that is up to the P/Ts because it is their budgets that are impacted. I have the sense that the P/Ts do want the policy because of the impact.

This policy makes sense in that some conditions can be life-long, chronic, or need specialized treatment and the costs can add up quickly. Right now our immigration policy is very focused on economic integration. Many ED cases could be contributing economically but also be a cost in terms of health care or social services. Really would need to do a cost benefit analysis to understand the value.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

For PRs it makes sense to screen them all and then we can ensure that they are linked to the notification. A bit unsure about how TRs are treated. This is a bit of an odd issue because we have all of these visitors that are coming into the country and so many Canadians travelling abroad and then returning to Canada. So we have one segment of the population that undergoes screening, but all of these other people that could be posing a risk.

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

There are guidelines for the Panel Physicians and OP15 for the visa officers. There is a handbook for MoFs.

a) **How effective are these tools, training, guidance, etc?**

The handbook for MoFs is very out of date (1992) so there is a lack of written materials for them.

b) **Are any improvements required?**

The MoF handbook should be updated.

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

Cannot comment.

a) **How effective are these tools, etc?**

Cannot comment.

b) **Are any improvements required?**

Cannot comment.

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with delivery partners of the HSN Program?**

Did not note anything specific.

a) **How effective are these mechanisms?**

No comments.

b) **Are there any barriers?**

There are issues related to the notification component of the program. There are good working relationships at the working level (between CIC and P/Ts), but not at a higher level.

c) **Are any improvements required?**

No comments.

11. **What changes have been made to the medical screening and notification program as a result of modernization?**

Cannot comment. E-medical was implemented when working in the Branch, but was not kept informed on this.

a) **What has been the impact of modernization?**

Cannot comment.

b) Have there been any gaps or challenges?

Cannot comment.

12. **Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?**

Cannot comment.

a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?

Cannot comment.

b) Do you have any suggestions to improve clients' awareness and compliance?

Cannot comment.

13. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

Cannot comment.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

Cannot comment.

14. **To what extent has the HSN Program:**
    a) Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How do you know this?)*

Cannot comment.

b) Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this? Are there any other benefits of the program to Canada?)*

Cannot comment.

15. **Have there been any changes to the program that have made operations more efficient?**

E-medical, but cannot comment on it.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

There some resource issues within the Branch so the focus is really the operations and getting the IMEs and the IMAs done. There has not been a lot of support for PHLU. With the resource shortage, the Branch has had to be more active than strategic. It was very hard to get any policy input from the Operations side, because they just didn't have the time and resources.

b) **Any suggestions to improve program efficiency?**

Nothing noted.

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

Cannot comment.

Other

SK suggested that we may want to interview David Manicom to get Immigration Branch perspective.

INTERVIEW GUIDE - CIC STAFF - NHQ

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification Program?**

2. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes, they should for 2 reasons: for health risks related to movement of people, we should be aware, it is the government's responsibility to know and assess what we are bringing in and those conditions that could threaten health, public safety, or those conditions that could be a burden.
This should be done to mitigate risks, and should be done as deterrence.
[Regarding Furtherance] A lot of those files would be stopped, and files would be closed.
[Regarding] Exam and Assessment, equal in importance, go hand in hand, not separate functions.

b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

Yes, it is a good component of the program due to reactivation or a risk – they must be connected to internal [health] system. It is a good idea – it is a part of our obligation, we should connect them [migrants] to our health system. But it is not an efficient way of doing it, we are not connecting them well, process has to be re-thought.

JM – why not efficient?

The process is complex, huge amount of stakeholders and many factors. There are the conditions found requiring medical surveillance at missions, note on passport... Variables are many [arrivals - timing and destination] and we don't have control.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Yes. Screening for security is a good example, someone who is a threat to security of country would be investigated for threat, no difference for health screening. I see role as similar- our responsibility. If logic is good to screen for security do so for health.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes. Our role – our medical exam, our client. Onus is on us to pass message on, no question on role. Need to make process more reliable.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

No. Enhancements on the [current] processes are needed for example the US has screening labs for TB. We have a quality and standards issue.

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes. The screening is necessary to whether it is a danger or could be managed.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

Unsure. I can speak to the fact that FCC countries screen for TB so that is relevant, they are not screening for syphilis and HIV.
Referring to Canada, we should look at internal medical conditions. Some analysis needs to be done based on risk to our own internal pressures, to mitigate risks of migrations of people. We should consider internal need in health context. There should be a cost-benefit analysis based on health assessment and what immigrant offers.

JM - [Who should determine this]

Combination of people/entities, health practitioners/authorities. There should be a cost-benefit analysis, it should be the doctors.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

No/Unsure. This is a harder policy to implement and screen for. According to our statistics, less than 1 – 5% per year during 1st year [are found to be a danger to public safety].
It is a risk, don't want to bring in someone with a mental health problem, but very hard to know, it is hard to screen for and implement.
Is there a need? I would say no, results are not justified by the numbers we found in implementing the policy. We can't quantify the results.

JM – If policy doesn't exist?

It is a question of definition. We could find mental illness under screening for public health. It is not found to get results under this policy.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Could not comment.

6. **Is the policy on Excessive Demand still needed and relevant? Why or why not?**

Unsure. According to our statistics, most of our excessive demand cases are exempt, the work for costing is a big demand only to find out they're exempt.
Have to think of costs going into doing these assessments.

7. **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Yes and No.
[For No] If we look at it from a surveillance point of view, then no we're not screening the right people. But there is a practicality to the economic impact on having 100% coverage. [Regarding screening of TB] There are some people who we don't screen like those from US, UK... if they come, have TB, and are not staying long, we're not screening... [must consider burden of risk assessment].

[For Yes] We are screening the people staying a longer period and this is assuring. We are screening those that are higher risk.

8. **What tools, training and guidance are available to support the delivery of the Health Screening component of the HSN Program?**

There are a few gaps in delivery of the program. This is probably because of technical aspects, geographical aspects... We have requirements, exams, [certain] age groups, documents; we have pre-designated health partners who are authorized, our own medical officers – good controls.
We do not have a good quality assessment – a quality gap, no global solution to address gaps in different places [who use older tools, assessments, technology] and we don't assess what is needed there.

   a) **How effective are these tools, training, guidance, etc?**

We do assessments; we don't have quality review, no follow up on decisions that have been made.

[Regarding Training] Very little training on our part. [Process] at the border [is an example], i.e. numerous Acts to consider, we don't provide good training.
Need a risk based approach to screening, exam and assessment. There is a lack of this.

[Regarding panel physicians] Not monitored - We never check on this quality. No follow up.
We check them on credentials but never again on their practice. There are visits every now and then, but visits done every year – may be 50-100 out of 1000 panel physicians every year.

JM – what is done when panel physicians have questions?

They know to go through the RMOs, but questions are not medical, they are technical – on forms and procedures.

b) Are any improvements required?

Quality control, developing a quality control regime.
Quality assessment, we had done, but not sure if the framework was put in place/implemented.
There are some controls regarding data - data integrity checks, but it is not at the level it could be.

9. **What tools, training and guidance are available to support the delivery of the Medical Notification component of the HSN Program? *(Probe: tools and info that PTs & LHAs use / info for clients?)***

[This component] needs a lot of refurbishing. Effectiveness is very low, it is a manual process.
Everything is in GCMS these days... but this is a manual process.
The medical exam is now in eMedical and the information goes into GCMS, not hard to pass on the information to the Provinces, but this is not done. We cut and paste the information into word documents and then send it by mail to the Provinces.

a) How effective are these tools, etc?

Errors are possible.

b) Are any improvements required?

Yes. There is no guidance on Provincial/Territorial needs, very little training at border; it is a process that needs help. Given the huge modernization plan, this is not picking up speed.

10. **What kinds of communication and coordination mechanisms (e.g., meetings, fora) are in place to engage with Medical Notification delivery partners?**

This is the weakest of the links because it involves various levels of government... weakest in terms of communications.
[Regarding Screening] Very little communication. There used to be training visits, phone calls, to establish relationships - see them, see client group. Doing business from a distance not a good practice, need feedback mechanism [to] know concerns.

a) How effective are these mechanisms?

[Regarding Notification] Saw more communications when groups of refugees were coming in. On implementation of program side of things, this is lacking.

On Exam side [screening], it is more decentralized, RMOs, have own geographical area of coverage – More frequent? Unsure... but contact not as stagnant as medical notification, not as passive.
It is lacking because apart from updates, visits, not much communications...

b) Are there any barriers?

Yes. There are lower cost options to engage [e.g. Skype] those people on a regular basis [in regard to] on communications, updates, on quality, engagements, training, quality assessment. Currently not doing this, just dumping information.

c) Are any improvements required?

Yes. Modern technology.

11. What changes have been made to the medical screening and notification program as a result of modernization?

There are cost cutting trends which has meant reduced travel, etc.
Our RMOs are decreasing, we had 10 now 5... Territory is growing, a long travel for a lot of people.
New ways of outreach – to reach out to panel practitioners (labs, etc).
There is room to implement oversight and check function... no checks/monitoring [e.g. correct photo with correct medical file].

a) What has been the impact of modernization?

Need to check function on automation process in eMedical.
GCMS takes a long time – it is a slow system, very inefficient.
A risk in eMedical is that is it a joint project with Australia. Since Australia has the system, we have operational risk, dependence on Australia's technical expertise.

b) Have there been any gaps or challenges?

Notification has to be modernized, it is incredibly dated. Is up to partners...
GCMS gap, haven't gone that far [in regard to modernization], not priority.

12. Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?

Unsure. We do provide them with information they need, in different languages.
Question if the information is being absorbed by the client.

a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?

Some clients do realize they have a case, requirements on them, but medical requirements are not the only requirements [for an immigrant's arrival in a new country].
[Medical requirement page] It is important piece but could have gone over it for sake of [other needs].

b) Do you have any suggestions to improve clients' awareness and compliance?

Yes. People with medical conditions are identified at mission or at an office internally. Those coming from outside, at border, they are stamping... if that person would confirm their address or their arrival date that would help... something that would flag for Health Branch, to link them.

13. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?

No information to measure this. Don't have quality checks so can't answer this...

We are identifying for public health [but] need quality checks [as we] may be missing some. For Public Safety, can't say.

a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

Yes. Short term stay or not a designated country.

14. **To what extent has the HSN Program:**

a) **Reduced the burden on the health and social services in Canada? Please explain.** ***(Probe: How do you know this?)***

On Excessive Demand, not short term outcome. Must be monitoring TB, HIV, etc and link to populations coming in... Indicators we don't have. We know 200 cases refused. We have other burdens which we cannot measure.

b) **Protected the health and safety of Canadians? Please explain.** ***(Probe: How do you know this? Are there any other benefits of the program to Canada?)***

15. **Have there been any changes to the program that have made operations more efficient?**

Yes. One is eMedical, has really downloaded data entry work to Panel Physicians.
The restructuring of Health branch and of RMOs and redefining activities done by RMO.

a) **Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?**

Identification of ED – no issue – it is good, but costing of Excessive Demand and assessment is different – not effective.

b) **Any suggestions to improve program efficiency?**

Assessing Excessive Demand is where the issue is, we don't have tools, [there are] costs to provide them (to our Medical Officers).

16. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

No. On screening side, no cost for us. Applicant pays doctor for screening. There is quality assessment [needed] though...
On surveillance notification, whole process of entry of data could be automated...
No don't think so.

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE – Public Health Agency of Canada

1. **Can you please describe your area of expertise as it relates to migration health, immigration, or infectious diseases?**

There's a list of diseases which are grouped together because there's a greater impact on certain higher risk populations such as immigrants. These conditions include TB, STIs (blood born illnesses such as syphilis, HIV, Hep B/C). We work with P/T authorities and CIC on these matters.

We give our expertise to CIC on public health conditions such as which countries have higher incidences of TB. We've given technical advice on testing for Heb B and HIV.

2. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada and/or your departmental priorities? In what ways does the Program align/not align?**

Yes, I would say so from a public health perspective. By screening for infectious diseases and conditions, it's to the benefit to migrants (because of treatment) and the Canadian public.

3. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes – so as to reduce the public health risk posed to Canadians from immigrants (foreign born individuals have higher incidence of TB). It's in the best interest of the individual with TB and all those they come into contact with that they are treated.

   b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes – However, the word surveillance has a negative connotation. We should change it to a more appropriate term. They are really going for "further public health follow up."

4.
   a) **Considering each of these federal responsibilities, is the federal government's current role appropriate:**
      - **In facilitating medical examinations and conducting assessments?**

Yes. The theory of what should be done by the federal government is fine, but in terms of operationalizing that theory, I think needs some improvement. [see below]

      - **In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

The referral from CIC to P/Ts of clients needs to improve. The handover element is an important role that the federal government should be more engaged with. There are a number of people who are lost because they are not followed up or tracked due to interprovincial movement. There's also no accompanying medical information for those who do follow up with the local health authority – so the local physicians are essentially starting from scratch or waiting months for medical information to arrive from overseas. If there could be some way for that information to be transmitted automatically or accompany the client, that would greatly improve the surveillance process.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

What I mentioned is a gap.

5.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

There should be this policy but it's not wholly relevant. Meaning, if syphilis is on there I'm not quite sure why a number of other conditions aren't on there.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

It would be good to capture Hep B&C.

6.

a) **Are we screening the right applicants and populations of applicants? Are there any gaps?**

I can't really speak to that. It's my understanding that there's nothing special about the 6 month rule, it's simply a policy decision because there needs to be a cutoff somewhere. I think it's a reasonable timeframe in terms of TB. There's certainly also a cost-benefit and risk mitigation element to this.

7. How does CIC engage PHAC with respect to issues related immigration and public health, and more specifically with respect to the HSN program?

MoUs with annual workplans. Meetings with Dr. Grondin. TB is a priority for both ministers. We have monthly teleconferences.

a) Is the nature and level of engagement appropriate?

Yes it's appropriate and good

b) Are any improvements needed?

No. There are many priorities to manage and there are resource and capacity issues at play.

8. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

Fairly effective but there are some gaps. We know that foreign born individuals in Canada have some of the highest incidences of TB of any group (aboriginals is the other high risk group). Even when looking at the Canadian born population with TB, most of these cases are contracted outside of Canada. For this reason, I think we should be screening not only for active TB, but also latent TB.

The primary means of detecting TB is currently the chest X-ray but X-ray images can be tampered with and they aren't always reliable because they can't detect certain strains of active TB or latent TB (where there is no previous scarring such as with inactive, treated TB). We should be doing a TB skin test or IGRA test at the IME to determine latent TB – especially in higher risk situations.

But I certainly don't think we miss many TB cases or really, any syphilis/HIV cases.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

CIC is moving to fill the gap in terms of testing for latent TB. CIC needs to develop and implement systematically a policy whereby the family members of applicants with active TB should undergo more rigorous testing (IGRA/skin) because these people have a higher chance of having latent TB which would not show up in a chest X-ray.

b) Are there any data available on active TB cases within in the immigration population in Canada?

Yes. In terms of the foreign born population, these are publicly available on our website. The highest numbers of FB TB cases are from India, China, Philippines, and Vietnam (may not be in that order). However, we don't have robust data from P/Ts as to the degree to which recent immigrants have active TB and the number of TB surveillance cases vs active TB cases found outside of surveillance.

Dr Archibald would be the person to get specific data.

c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

Again, this is not available. Not systematically collected and not reported at the national level.

9. To what extent has the HSN Program:

a) Reduced the burden on the health and social services in Canada? Please explain.

Not sure. No data apart from the fact that people who have active TB are prevented from entering Canada.

b) Protected the health and safety of Canadians? Please explain.

Not sure. Same thing as above. We don't have good data on this.

INTERVIEW GUIDE – Public Health Agency of Canada

1. **Can you please describe your area of expertise as it relates to migration health, immigration, or infectious diseases?**

We don't deal with all infectious diseases – only a subset. We deal with HIV, TB, other STIs, and Hepatitis.

2. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada and/or your departmental priorities? In what ways does the Program align/not align?**

Yes, it aligns well – the HSN Program has an objective of reducing and preventing the spread of infectious and transmutable diseases to Canadians. These align with PHAC and GoC priorities.

3. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes. In particular, diseases which can be spread due to more casual contact such as TB, should be screened for. Not screening would increase the burden of risk for Canadians. There would be a risk of transmission in Canada so it's an obvious thing that should be done.

   b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Yes. There is a fair amount of evidence to show that TB can reactivate, even once treated – especially due to stress - and immigration is a stressful process. So there's a need to connect these individuals with the care they need once they arrive and to prevent the possible spread of the disease. The first few years after arrival are the highest risk period for reactivation, and I believe that's the focus of the surveillance program.

There has been some discussion regarding placing people under surveillance for HIV. Not so much because of the disease itself but because these individuals (who have autoimmune type disorders) are at a much higher risk of contracting TB, especially if they frequent other TB endemic countries.

Treated syphilis is already placed under surveillance. But there needs to be further assessment of other types of diseases (such as Hep B and C) as to what responsibilities federal and provincial governments have in terms of connecting and monitoring these conditions within the immigrant population.

4.

   a) **Considering each of these federal responsibilities, is the federal government's current role appropriate:**
      - **In facilitating medical examinations and conducting assessments?**

Yes it's appropriate – I'm not really sure who else would do it considering entry requirements are the constitutional responsibility of the federal government. The P/Ts certainly couldn't do it. In terms of engaging with PPs, I'm not quite sure how CIC determines the suitability of these clinicians but the more we can involve international organizations (such as IOM), the better, because it would add to the credibility of the screening process.

- **In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes it's appropriate. It falls in line with the responsibility in screening. If the federal government is the one detecting these conditions, then it follows that they should be the ones to notify the provinces, under whose responsibility, health matters fall.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

No.

5.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes – but some thought should be given to other conditions that arise from time to time such as H1N1 and other influenzas. I would hope the policy and procedures are flexible enough to deal with these conditions.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

Generally yes. (answered above)

6.

a) **Are we screening the right applicants and populations of applicants? Are there any gaps?**

I think yes. I understand there are cost-benefit issues at play here but I think we should be working together (CIC and PHAC) to look through the data and identify the prevalence of TB among visitors from certain countries to see if we're missing some.

7. How does CIC engage PHAC with respect to issues related immigration and public health, and more specifically with respect to the HSN program?

We have monthly teleconferences with Dr. Grondin's group to discuss issues like TB. So we have frequent contact there and we also have data sharing agreements, to share data on HIV and TB primarily. ADM/DG level meetings happen as well. They discuss largely TB issues.

a) Is the nature and level of engagement appropriate?

Yes.

b) Are any improvements needed?

Both sides are very busy. We haven't always actioned the items identified at meetings. We could do more on this.

8. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

It's fairly effective. We lack some longitudinal data to identify the full extent of the effectiveness. We have data gaps from the provinces because we lose some clients due to movement. As a result we don't have a full picture.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

The biggest gap is the linkage to public health. People show up to the P/T office and they have no medical records. They don't know what conditions they have or they only have scant knowledge of what they have like treated syphilis – but they don't know what treatments they received.

The federal government should be clearer to the incoming immigrant before arrival of the conditions they have. Newcomers (especially those with identified conditions) should arrive with full medical records. I'm not sure why in every situation this has to be requested from CIC well after their entry.

b) Are there any data available on active TB cases within in the immigration population in Canada?

Yes we have this data. It's in our surveillance reports. It's publically available - CIC has them. There are more detailed information so you'd have to make a request for this.

c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

There's some data on that but it's not as complete as we'd like because we don't always get this information from P/Ts.

9. To what extent has the HSN Program:

a) Reduced the burden on the health and social services in Canada? Please explain.

I don't have any data, so I don't know. CIC may be in a better position to cost out the information from how many people they've identified through the IME process, but we don't have any cost information.

b) Protected the health and safety of Canadians? Please explain.

I don't have data. Subjectively, I think it's had an impact. Anecdotally I know of cases which have been found and these I would assume led to the reduced risk on health and safety of Canadians.

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE – Public Health Agency of Canada

1. **Can you please describe your area of expertise as it relates to migration health, immigration, or infectious diseases?**

My area of expertise concerns HIV, STI, TB, and other communicable diseases. I work on guidelines and public health practices and the evaluation of public health practices.

2. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada and/or your departmental priorities? In what ways does the Program align/not align?**

Yes – It aligns with PHAC's priorities of trying to prevent the spread of transmutable diseases – especially to the Canadian public. This is also in line with Canadian Government priorities of ensuring public security/safety.

3. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

Yes – but only for some conditions. CIC tests for Syph, HIV, and TB. Screening and assessment is needed on these conditions because there are significant public health concerns associated with these illnesses. It depends on the condition of course; there could be a severe public health risk. Syphilis, for example, should continue to be screened overseas and treated using Canadian guidelines. If this wasn't done, there would be a risk of spreading it to Canadians once landed or there is a risk that the applicant would never find out about their condition and thus not benefit from treatment.

If there was no screening, we would see an increase in TB cases in Canada.

b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Generally yes, but not for all conditions currently on the list. Chiefly, while it is important to screen for syphilis, once this is treated overseas, there's very little need to continue to monitor the patient from a public health perspective. There is also no evidence to suggest that people contract syphilis in Canada due to failed screenings/treatment procedures [of Syphilis] overseas. As long as they are screened and treated overseas, there's no risk of transmission and, therefore, these people should not be placed under surveillance.

But TB of course needs to have medical surveillance [as well as proper screening and treatment overseas due to risk of reactivation].

4. **Considering each of these federal responsibilities, is the federal government's current role appropriate:**
   - **In facilitating medical examinations and conducting assessments?**

Generally, yes – but I think that the federal government is the right organization to have oversight of the screening procedures and assessment for immigration process. But, part of their responsibility is in providing the medical results to the newcomer, who presently doesn't get a copy to bring with them to Canada. So they don't really know the details of their own health. They don't know what type of Syphilis they have, what tests were performed, how they were treated. It's very frustrating for public health practitioners because they are required to contact CIC for this information [which could take months to obtain]. This is a very convoluted method because there is a lack of continuum in the federal role between the screening component and the surveillance component.

The federal role should include providing a complete medical package to the immigrant, with a detailed record of their medical history, treatments they may have received – what vaccines they were given – etc.

- **In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

I think the role is generally appropriate for the conditions that need surveillance – primarily for TB. I already mentioned I don't think treated syphilis requires further surveillance. I also mentioned that notification should be accompanied by a full medical package on the newcomer.

a) **Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?**

None identified. [comments relate to other questions]

5.

a) **Is the policy on *danger to public health* still needed and relevant? Why or why not?**

Yes, we have the right list of conditions to render someone inadmissible. Of course there are serious conditions of concern like Ebola or if there is an outbreak situation, the current policy may not be flexible enough to accommodate temporary changes in public health.

b) **Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?**

No real gaps – except in terms of short term medical concerns I already mentioned.

6.

a) **Are we screening the right applicants and populations of applicants? Are there any gaps?**

Yes – but it's worthwhile to look at the sources of data to seen whether there is a cost-effective way to screen certain sub populations. Because there may be a risk we're not catching.

7. **How does CIC engage PHAC with respect to issues related immigration and public health, and more specifically with respect to the HSN program?**

I work with CIC actively on a number of fronts. We consult with newcomers on health issues and I work with

CIC on these results. 5 or more years ago there were regular meetings at the working level, there are national committees – this was very useful. The new reality is that now these have been disbanded because of budgetary issues. This has hurt the ability to discuss emerging health issues. The ADMs do talk to each other. You can't just have talks at the top though.

a) Is the nature and level of engagement appropriate?

More working level interaction is needed.

b) Are any improvements needed?

More working level interaction is needed.

8. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?

CIC should examine/evaluate its screening procedures and the different conditions it basis its policies towards a more risk-based and targeted approach. Perhaps you don't need to screen TB for people from certain countries. Perhaps you need to screen people coming in for less than six months but from TB endemic countries. Answering these questions could create a lot more cost effectiveness in the Program.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

No other gaps.

b) Are there any data available on active TB cases within in the immigration population in Canada?

Yes, we receive data from all provinces on active TB cases and these include foreign born populations. These are eventually published and made publically available. You can take a look at our online website to see if there is data there and if not sufficient, we may be able to provide what is missing.

c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

This is not something that is reportable. This is a research issue for a study.

9. To what extent has the HSN Program:

a) Reduced the burden on the health and social services in Canada? Please explain.

I have no idea. Theoretically, the diagnoses and treatment of TB and syphilis overseas prevents these people from coming into Canada. This reduces the burden on the health and social services. But I have no data on the extent or any knowledge of how effective surveillance is at reducing burden in Canada.

b) Protected the health and safety of Canadians? Please explain.

No idea - theoretically, same answer as a) above.

INTERVIEW GUIDE – Public Health Agency of Canada

1. **Can you please describe your area of expertise as it relates to migration health, immigration, or infectious diseases?**

2. **Do you feel that the HSN Program aligns with the priorities of the Government of Canada and/or your departmental priorities? In what ways does the Program align/not align?**

It doesn't quite align with Government of Canada priorities.

It does not screen for immunization, for example vaccines prior to coming to Canada. As people approach Canada they should have their immunization records. These records would allow them to engage public health so that they don't have to start from scratch. It would ensure that they have received the appropriate doses of medication. For example, for Polio, have they received the full primary series? It's the same situation for Measles and Rubella. This would allow for people to contribute and not just take advantage. It's a gap by not having the records, and it's important to have a document to address the gaps.

3. a) **Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

It allows for the migrants to engage with public health jurisdictions as soon as they get to Canada. With active syphilis and TB, it's important that they have at least initiated their treatment. It's preventing the safeguard, before public health could even intervene.

   b) **Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?**

Someone from public health needs to evaluate them. With Inactive TB, there is a 10% risk of it developing into active.

Not sure what the need is, as someone could continue to monitor them and thereby avoiding them getting lost in the system. However, not sure inactive risk is high enough to justify surveillance, as there are other things to keep in mind such as age, immune compromising system (i.e. Cancer treatment). If they're only looking for reactivation, it's a 10% risk, and that questions the need for surveillance. If they have active TB, they could be spreading it when they arrive.

4.

   a) **Considering each of these federal responsibilities, is the federal government's current role appropriate:**

The intent of medical examination is limited to certain considerations, for example, have they been vaccinated appropriately.

As far as they know, CIC is the gate keeper. They think it is appropriate.

- **In facilitating medical examinations and conducting assessments?**
- **In identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes, there is an obligation to local public health to inform of any risks associated. Its purpose is to ensure as much as possible that people won't be spreading untreated illnesses (TB, syphilis, measles, polio). This may also be caused by going back to country of origin and then bringing it back.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

Not from a PHAC perspective.

5.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

[Already discussed in question 2]

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

Polio and measles vaccines can be identified as a gap. The migrants are at risk for spreading if they are not immune, either through airports, or refugee camps. It would be appropriate to screen and for the migrants to have something with them to document their immunity status. It would facilitate the intake.

6.

a) **Are we screening the right applicants and populations of applicants? Are there any gaps?**

A TB risk based approach is appropriate.
With syphilis, not sure how relevant the knowledge is.
Concerning Measles/rubella, the Americas are Measles/Rubella free. WHO regions of AFRO/EMRO – Polio is still circulating. They could take a risk based approach as well.

7. **How does CIC engage PHAC with respect to issues related immigration and public health, and more specifically with respect to the HSN program?**

CIC/PHAC DG level committee that meets on a regular basis. This is where these kinds of issues are discussed. In the last 3-4 months, polio has been introduced into Syria. Refugees are potentially susceptible, thus the need for up-to-date immunization records.
CIC has not really done much with immunization – don't have a lot of contact. For the TB/AIDS/Syphilis group, the DG of the Centre is co-chair with CIC.

a) Is the nature and level of engagement appropriate?

Yes

b) Are any improvements needed?

Yes

8. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., inactive TB and untreated syphilis)?**

Don't know

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these

clients?

Don't Know

b) Are there any data available on active TB cases within in the immigration population in Canada?

No specifics (not responsibilities). For Canada born non aboriginals, there is lower TB numbers. For Canada born aboriginals, there is higher TB. For immigrants, there is double the TB levels of Canadian Born non aboriginals.

c) Are there any data available on inactive TB cases in the immigrant population that reactivate after arrival?

No.

9. To what extent has the HSN Program:

a) Reduced the burden on the health and social services in Canada? Please explain.

Don't know

b) Protected the health and safety of Canadians? Please explain.

Don't know. Active TB/Syphilis are usually picked up and allowed to come to Canada.

Evaluation of the Health Screening and Notification Program

INTERVIEW GUIDE – RMO –

As you may be aware, the Evaluation Division of Citizenship and Immigration Canada is presently conducting an evaluation of the Health Screening and Notification (HSN) Program. The purpose of this evaluation is to examine program relevance, program management and delivery, and program performance.

As part of the evaluation, members of the evaluation team are conducting interviews with key stakeholders involved in the Program. The evaluation covers program activities from 2008/09 to 2012/13. The following questions will serve as a guide for the interview. The responses you provide are confidential and will not be attributed to you in the evaluation report (only aggregate information will be released) or in any documentation.

1. Can you describe your role and responsibilities in the RMO?

I do medical assessments for Canada based on PH, PS and ED. The purpose is protecting cdns from particular diseases.

We do 70,000 cases a year. Currently have a M05 procedural fairness backlog of 100 files. The office is closed down for new cases. We are keeping all the old files in Beijing except for the new ones which go to

Program Relevance

2. a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?

YES. Prevent diseases in Canada related to PH, ED, PS and it is still very relevant. If we prevent 2 schizophrenics, we've paid for ourselves – even only 100 refusals a year we've saved the government a lot of money.

b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

YES – very important – helps prevent diseases of PH significance and also helps the migrant that has the disease by informing them how to effectively treat it. Important to protect Canadians from TB activating.

Program Policy and Design

3.
a) Are the policies on *danger to public health* and *public safety* still needed and relevant? Why or why not?

Yes, in general both are relevant.

Evaluation of the Health Screening and Notification Program

PS: I don't think we do enough for the mental part – I think we miss people that are anti-social or have problems that aren't necessarily a danger to PS. Maybe it requires changing the legislation to be able to screen people how who have mental issues that aren't necessarily dangerous, but would prevent them from functioning in society.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health and public safety? Are there any gaps in this policy?

TB yes. However, Syphilis is easily treated these days, it should be removed from the legislation.

Maybe consider Hep B and C and HIV because it is a costly disease and public health reasons – HB should look into this more and make a decision.. Australians already deny people with HIV+. We need to make a decision on this. We have a lot of TB and Hep B and C here

The safety part we could improve – someone can act normal in front of the Doctor but have mental problems. Not sure how to have better tools though.

4. Is the policy on Excessive Demand still needed and relevant? Why or why not?

Some treatments are very expensive and Canadians shouldnt have to pay for it. The government needs to decide what to do. There is a Deterrence effect – a lot of people pre-assess before deciding to come to Canada. In general, the threshold for ED is sufficient.

Problem is that Hep B treatment has decreased recently putting people under the ED threshold, so we are accepting people now that we were refusing last year. Young immigrants who need to have Hep B or C treatment for 20 years will cost the tax payer a lot of money. Need a nuanced policy.

5. Are we screening the right applicants and populations of applicants? Are there any gaps?

Not sure. Canada has to decide these things. Do we need to screen specific populations instead of treating everyone under one umbrella? Not sure.

Program Management and Delivery

6. Who are the key program partners/stakeholders that you work with?

PPs and PRs, Visa Office.

a) What kinds of communication and coordination mechanisms are in place to manage the screening and notification components of the program?

s.21(1)(b)

PPs: we comm using email and telephone. We have a personal touch in Beijing when it comes to dealing with PPs – assistants deal with them on the phone and answer questions. Nature of comm is mainly case by case communication e.g. if there are any errors in the IME or if they don't understand certain these things / procedures.

b) How effective is the communication and coordination between:
   i. RMO and Panel Physicians/Radiologists?

Good relationship with PPs in general. but our role is changing a lot. We've had a personal experience with the PP but we are losing the personal touch – have a face to it. A lot of PPs don't speak English in

   ii. RMO and CIC NHQ?

It is effective. Monthly teleconference with all the MOs. To try to smooth things over with the glitches with e-medicals.

   iii. RMO and Visa Offices?

Rarely communciate with visa offices, but good relationship (effective). Ad hoc nature. Usually about a case. Visa Offices usually leave us alone because we are very efficient.

   iv. Other?

7. What tools, training and guidance are available to support the delivery of the IME and IMA process?

Hasn't been much guidelines for e-medical and medical officers, but they are working on an updated handbook for MOs. Have a medical handbook for PPs.

a) How effective are these tools, training, guidance, etc?

PP guide – yes it is effective tool.

b) Are any improvements required?

There is always a need to update the medical procedures and guidelines. There are lots of problems and fixes in e-medical.

8. What procedures does this RMO undertake to ensure that panel physicians are following IME guidelines? (QA, Monitoring, etc.)

With e-medicals its easy to let them know if they've missed something. System wont let them submit an application without certain requirements met.

Evaluation of the Health Screening and Notification Program

We have case by case communication if we notice an error. We have a QA audit every year which is a self assessment the the PPs fill out with profile information, ask PP a lot of questions have they changed their email, how many cases they've done, TB in ates, etc.

We used to travel and go watch them (site visits)– now there isn't any travel budget. Have a travel tool. Normally used to take notes in a notebook if a PP is having trouble.

E-medical has a audit in there but have no idea how it works because we don't have the time.

a) Is this consistent across all RMOs? Are there any RMO-specific procedures that you follow?

We each pretty much have the same procedures. Self audit, site visits are the same.

b) How frequent are these procedures undertaken?

Site visits – 3 times a year. Now once every 2-3 years because the PPs are well established.

c) Are there any gaps / areas for improvement?

We don't have enough medical officers to do QA all the time or to go on site visits as frequently – Mos don't have time to leave the office all the time.

d) How is the information compiled and reported? (reviewed at the RMO level, reported to NHQ, etc.)

Site visits – compiled into a report.

9. In your opinion, are IMEs being conducted consistently across the network of panel physicians?

Basically yes – pretty easy to do a complete medical. If we train people adequately, there is no problem.

a) Are there any challenges with the IME process? Any areas for improvement?

Better training of PP could improve consistency.

You cant do QA completely on a machine – need some face to face.

10. In your opinion, are IMEs being assessed consistently across the network of RMOs?

Generally yes – except for the grey area – M05 and M03. Some MOs will pass them and some won't. Some are MOs more compassionate. The grey cases MOs can go either way.

In terms of making sure the RMO assesses files correctly, we talk to the assistants once a month as a group – if there are any issues we tell them about their work.

a) Are there any challenges with the IMA process? Any areas for improvement?

Improvement would be have specific guidelines on certain areas. Hep B is just below the ED threshold now where we were refusing them the year before. Should we be more consistent with this or have certain conditions like hep b and c always a refusal..

b) [*e-medical specific question*] Are panel physicians consistently and accurately entering IME information into the e-medical system?

Not asked.

11. To what extent are IMEs being conducted and assessed in a timely manner?

Definitely timely. Some PPs are open seven days a week now. Most people will get it in 3-4 days. 70-80% are being auto cleared. The other 30% - I am the one doing the final decisions. Some M05s are backlogged because the final decisions need to come from one MOF.

a) Are there any particular issues that impact their timeliness *(for what reasons)*?
b) To what extent do timeliness issues related to IMEs affect the overall processing of applications?

12. What changes have been made to the medical screening and notification program as a result of modernization?
    a) What has been the impact of modernization?

PP - it has taken them more time to conduct IMEs because e-medical is slower.. In the RMO – less clerical staff. In the long term, they are hiring LES medical doctors so they don't need as much MOs overseas.

Less travel and QA, because it costs less money.

b) Have there been any gaps or challenges?

Language is a problem in China. Even with e-medical webinars – we had to go over a lot of the material after because their language isn't as good as other countries. They will have problems in the Philippians because they are taking Chinese files without the necessary language ability (assistants).

We are going to have trouble moving forward with Hep B etc. and TB rates may increase since immigrants have the highest rates of TB in Canada. Until a year and a half ago we were seeing every chest x-ray, now with e-medical, if 3.4 it is auto cleared. If a radiologist wanted to pass someone tat shouldn't pass, they could easily without us knowing. There will be more misses. Sometimes I disagree with the 3.4s and make them a 4.1. You need to be safe and ask for sputums in certain areas.

E-med has made things slower for the PPs and the MOs. Because you have to keep changing screens – paper is much faster. Now the MO needs to go through every system. Need to click on more buttons

before we see the x-ray (click on many buttons). That is why I am behind – because of the slowness of e-medical/gcms assessments.

I personally think there are issues with centralization – not exactly stimulating work for MOs anymore. There is a less personal touch on things. You cant do QA completely on a machine – need some face to face.

Program Performance

13. Are clients with conditions of public health significance receiving sufficient information about their condition and requirements for surveillance?

Partly depends on the visa office. Also depends on the PP what he may have said to them. PPs aren't told to say anything – but some PPs do it. When they get to Canada, CBSA reminds them that they are supposed to be seen within 60 days.

a) What challenges does CIC encounter in making sure that those individuals understand their medical condition and comply with surveillance requirements?

Not asked.

b) Do you have any suggestions to improve clients' awareness and compliance?

Not asked.

14. How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?

I believe it is effectve, yes.

a) Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?

no

15. What do you think have been the key benefits or impact of the Health Screening and Notification program?

For the migrant it is very important; maybe makes them make lifestyle changes.

Resource Utilization

16. Have there been any changes to the program that have made operations more efficient?

E-medical has been efficient by auto clearing.

a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?

Assessment process is slower for the MOF.

b) Any suggestions to improve program efficiency?

Speed up the e-medical for us. We have to keep going to a new screen all the time. We need to do a lot of actually see the x-ray. Need to click many times in GCMS.

17. Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?

No. I think there is a big problem in China – high incident of TB. Anyone that wants to go to Canada for less than 6 months they can just go. Biggest visits are China and India – so we need a stronger presence in these countries. Temperature machines in PoE could help.

Thank you for your time and cooperation.

s.21(1)(b)

INTERVIEW GUIDE –

1. **Can you describe your role and responsibilities as they relate to the Health Screening and Notification (HSN) Program?**

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2. **a) Does the health status of migrants need to be assessed before they are admitted into Canada? Why or why not?**

- *Yes, medical conditions must be assessed in order to mitigate public health & safety risks, which do exist.*
- *Excessive demand is also an issue because if we do not screen for these cases, we could be flooded with high needs which would be costly. There is a political risk in not assessing.*

b) Should applicants with health conditions deemed to be of public health significance require medical surveillance upon arrival? Why or why not?

- *Yes – definitely, in terms of TB, as if TB reactivates, there's a high risk of spreading.*
- *Not sure if the word "surveillance" is appropriate; it's more like we should take care/manage the known conditions people have (i.e. TB cases) so that they find adequate medical care.*

What if there was no surveillance?

With respect to TB, there would be a risk of reactivation so there is a risk of propagation and therefore, is a risk to public health.

3.

a) In your view, is the federal government's current role in the HSN Program appropriate in terms of:

- **Facilitating medical examinations and conducting assessments?**

Yes, it is appropriate; it's not a role that can be given to anyone else. Other departments could play a role, but it's still a federal responsibility.

- **Identifying cases requiring medical surveillance and notifying P/T health authorities of such clients?**

Yes – Everything pre-arrival must be the federal responsibility. Surveillance must be given to PGs upon landing because we [the federal government] at that point loses [constitutional] jurisdiction. Since we screen and PTs perform surveillance, the role of notifying the PTs must be our role.

b) Are there other responsibilities which should be a part of the federal role? If so, what are they and for what reason should they be a federal responsibility?

We [the federal government] don't enough to mitigate public health risk. For example, there are other diseases which may be a concern such as polio. Cases of this disease are coming now from Syria. The PTs have turned to the federal government for a health policy response but we haven't developed anything. We should be maintaining contact with our partners. We should have a role in vaccinations. Currently, there is no campaign for vaccinations. It's about health protection. There is currently a lack of mandate.

4.

a) Is the policy on *danger to public health* still needed and relevant? Why or why not?

Yes – it's still relevant/needed. We need to mitigate public health risks. In the case of TB, this is a serious condition; it kills; it's costly to treat. TB has become almost eradicated from Canada with the exception of two communities: the First Nations and migrant communities. In refugees, the rate of TB is 300 times the rate of Canadians.

What about Hepatitis?

This is also a problem/concern. I'm not a specialist.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public health? Are there any gaps in this policy?

I'm not a public health specialist. But TB – Yes, definitely.
In terms of Syphilis, this has been screened for a long time (since the 40s). I'm not sure why it's still screened but PHAC wants others to screen for Syphilis because it's a blood test, so fairly easy to screen.
In terms of other sexually transmitted diseases, it's more operationally difficult to screen.

We could also be screening for things like SARS.

5.

a) Is the policy on *danger to public safety* still needed and relevant? Why or why not?

Yes - We have a duty to ~~do this~~ensure that people do not pose a danger. These conditions [which are a danger to public safety] are rare but it is still important to find them.

Cases are difficult to catch and identify properly. It comes out of the Visa Office through police certificates, psychiatric evaluations. There is no blood test we can administer for these conditions. It may

be hard to catch but we still need a mechanism in place to deal with conditions of danger to public safety.

b) Are we screening for the right conditions to determine whether an individual may pose a risk to public safety? Are there any gaps in this policy?

Yes – we generally look for the right things. We ask about their drug use, look into their history and identify through higher levels of suspicion.

6. Is the policy on Excessive Demand still needed and relevant? Why or why not?

- *Yes. Some people argue that only 2% are deemed inadmissible through ED, but there is still large cost prevention, as well as implication for the PTs. PTs may be better suited to answer this question; they bear the costs.*
- *Without ED policy, people may apply to come to Canada just so as to be treated by our health care system. The policy can act as a disincentive against this kind of behavior.*
- *In terms of appeals based on ED I'm not sure if there are problems but I know these appeals take a lot of resources. I'm missing some pieces of information such as the # of inadmissible. None of my cases in London went to the Federal Court. Perhaps we should rephrase the ED policy; i.e., in terms of calculation of ED. We should make the policy more clear.*

7. Are we screening the right applicants and populations of applicants? Are there any gaps?

- *Not sure. Work may be needed here. Designated countries are only based on cases of TB.*
- *6 months rule is also a bit arbitrary.*
- *We need to strike a better balance between closing borders and doing the right thing [in terms of public health].*

8. What changes have been made to the medical screening and notification program as a result of modernization?

eMedical was the big change.

a) What has been the impact of modernization?

eMedical streamlined the process of conducting IMEs and assessments. It moved us to electronic transmission of IME results. There is more security in this system. Processing times are better with 75% of IMEs being autocleared.

b) Have there been any gaps or challenges?

We need better QA procedures for eMedicals. Right now we are developing a more comprehensive QA framework which should be implemented by the end of this calendar year (2013). This QA framework will include SOPs, and reports on each process.

There has been no modernization on the notification side of the Program; this is problematic. There is no integration with GCMS. CBSA Officers at POE still fax the forms; CBSA is also not always compliant. Some

officers gather the forms once a month and some do it less frequently. Everything is done manually; we need a flag on compliance screen, as right now there is nothing in GCMS about compliance with surveillance.

9. **Have there been any issues, challenges, or successful practices which have had an impact on the management, governance, or delivery of the HSN Program?**

Successful practices:

- *eMedical system: This has been a successful practice and has had a positive effect on the Program. Files don't get lost as much (prior to eMeds, paper files would get lost); this has increased the integrity of the Program.*

Challenges:

- *The availability of resources is a challenge because we have taken on more activities and responsibilities related to FCC countries; we are engaged in activities that need more resources. Also, following from the Auditor General's review it was identified that we had to improve QA within the Program. We created an Excessive Demand unit in the Branch. All these things had to be done with existing resources.*
- *There has been a difference in the way different RMOs deal with their Panel Physicians [which has created challenges related to consistency]. We have a decentralized process, managed by RMOs; different offices have different expectations. But now we have a central panel management unit at HB which has developed SOPs to ensure consistency.*
- *Being a part of the FCC may pose challenges. We have a common management framework. We have aligned our PP Network with Australia. This alignment has required common standards, which has been written into a MoU between our two countries. This will increase partnership with FCC countries, which I think is a positive direction. However, the Program may become more complicated to manage. On the other hand, we will share work and this could lead to savings.*

10. **How effective is CIC's medical examination process at identifying migrants with diseases of public health significance (e.g., TB/syphilis), public safety and excessive demand?**

The medical examination process is outdated. The IRPA inadmissibility section as it relates to migration health is based on the 1976 act. It's based on mitigating public health risks that should be re-reviewed. In terms of TB, we pick up most of these cases, so the process is good in this respect. For what are required to screen for, we do it well (i.e., identify most cases).

In terms of public safety, we are looking for the right things, but cases are difficult to catch and identify properly. Applicants may not necessarily reveal these conditions.

In terms of excessive demand, we may not be identifying some cases; we concentrate on the most prevalent conditions. We are also trying to centralize the process through the ED unit so this may improve the process.

a) **Are there any gaps in CIC's health screening approach that affect the success of identifying these clients?**

Did not ask

11. **To what extent has the HSN Program:**
    a) **Reduced the burden on the health and social services in Canada? Please explain. *(Probe: How***

do you know this?)

Not sure. We did not conduct this analysis. The analysis could be done by multiplying cases caught by provincial information on the costs of these conditions. There's also an additional cost savings through the deterrence. The files are on ED are in each RMO but we also have the ~~file namesassessments~~ at NHQ. We will never be able to know how much we saved by deterring people from trying to come to Canada.

b) Protected the health and safety of Canadians? Please explain. *(Probe: How do you know this? Are there any other benefits of the program to Canada?)*

Difficult to evaluate in terms of public safety, the conditions are difficult to detect.

In terms of public health, TB remains the main issue. There are thousands of these cases and we do a good job of identifying them.

12. **Have there been any changes to the program that have made operations more efficient?**

There are common management tool but it's too early to tell if they've had an impact. Their theory and objective is good[sp1].

a) Have there been any challenges or constraints which have inhibited program efficiency or effectiveness?

Did not ask

b) Any suggestions to improve program efficiency?

Did not ask

13. **Are there alternative ways of delivering the program that would be more cost-effective and/or better achieve the program objectives?**

Maybe - The eMedical system is an Australian system so we are dependant on them in some respects. We have a MoU with the Australians regarding the system and how much we pay for it; we may be vulnerable here. For example, they could suddenly decide to charge twice the amount[sp2].

Pages 298 to / à 354

are withheld pursuant to section

sont retenues en vertu de l'article

13(1)(c)

of the Access to Information Act

de la Loi sur l'accès à l'information